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ABSTRACT

Described in a monograph published by the Technical Assistance Delivery System (TADS) are the rationale, intake and screening procedures, service delivery, liaison and follow through, and evaluation of parent training models from four preschool demonstration centers for handicapped children. An overview discusses the purposes and dimensions of parent training (social and emotional support, exchange of information, opportunities for parent participation, and improvement of parent child interactions). The university-affiliated program at the University of Washington, an example of a center-based parent training model, offers short-term, individualized parent training emphasizing home carryover of data keeping and behavior modification programs. Reviewed are three variations of the home-center parent training model: the carryover by parents of school instruction to the home, the teaching of new skills in the home, and the training of parents as volunteers in the center. Examples of parent lessons and child progress are included. Parent participation in a home-based program is exemplified in the Portage Project model which uses weekly prescriptions guaranteeing success for the parent and child. Finally, the parent implemented preschool model as seen in the Regional Intervention Program in Nashville, Tennessee is described in terms of the individual tutoring, generalization, and classroom training modules. An annotated bibliography of 18 citations is provided. (CL)

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TRAINING PARENTS TO TEACH
FOUR MODELS

By

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first chance for children · volume 3

In 1968 the enactment of the Handicapped Children's Early Education Act authorized the establishment and operation of model early education projects. These hundred projects are collectively referred to as the First Chance Network. The responsibility for administering this new program was accepted by the Bureau of Education for the Handicapped, Office of Education. The projects are designed to develop and demonstrate effective approaches in assisting handicapped children during their early years and are structured so that other communities can replicate, or adopt, exemplary components of the projects to meet their own needs in similar projects.

The Bureau of Education for the Handicapped has as its overall goal the equalization of educational opportunity for handicapped children by providing the leadership and resources needed to help the handicapped achieve their fullest potential and participate constructively in society to their maximum abilities. The long-range objective of the Handicapped Children's Early Education Program is to stimulate services to all estimated 1,000,000 preschool-aged handicapped children by 1980.

Technical Assistance Development System (TADS) was established in Chapel Hill, N. C. by B.E.H. to provide a wide array of special support services for the network of centers. Some of the services include identifying and providing consultants, holding small group workshops, collecting and dispensing data about the network, and conferring with individual centers and staffs. Most often, services are offered to First Chance projects in the areas of program planning and evaluation, intervention programs, community program development, and media and information.

First Chance for Children is a series of monographs published for the First Chance Network. The subject matter is drawn from the knowledge, skills, and techniques of the people who work within the First Chance Network and is collected and published by the Technical Assistance Development System.

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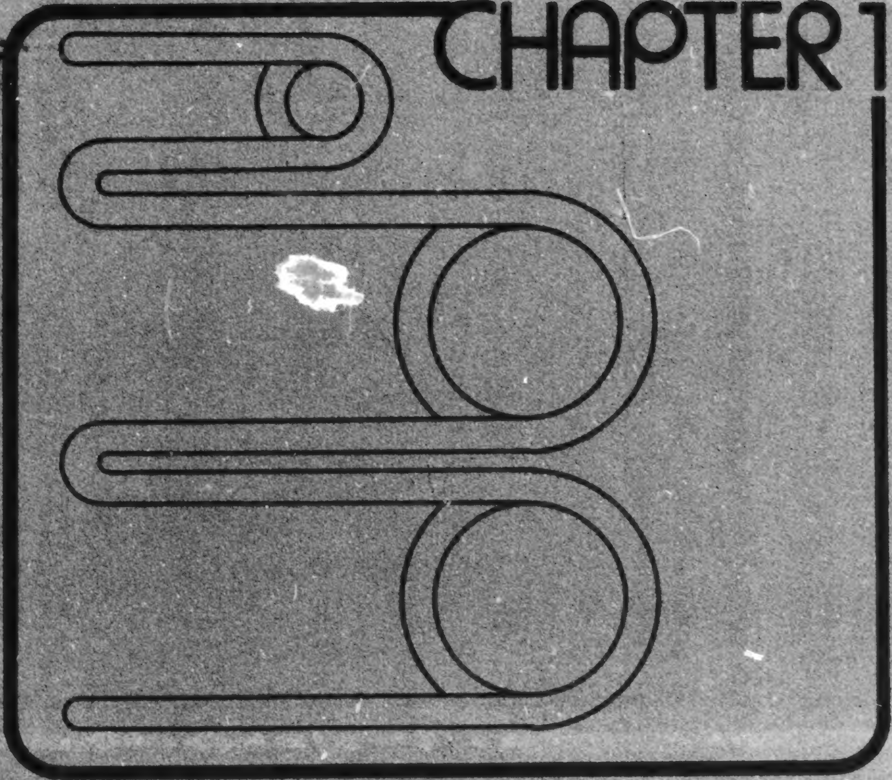
CHAPTER 1



Dimensions in Parent Programs: An Overview

By David L. Lillie

There is no doubt in contemporary thought about child development and early education that the extent of parent and family involvement is becoming more pervasive. Parents all across the country are finding themselves engaged in activities ranging from listening to a lecture at a parent meeting to making decisions about the direction that a child development program should take. Why this sudden rush to involve parents and families? Is a high level of parental involvement necessary for the success of a child development program? Are parent-oriented programs to take the place of child-oriented programs? What approaches are most successful? Certainly we don't have the answers to all of the questions that are being raised. But we do have a substantial base of knowledge to draw on as we discuss the dimensions of parent and family programs for the development of young children, particularly young children with special problems.

One substantial pool of knowledge of parent programming is the First Chance Network. Officially known as the Handicapped Children's Early Education Program, this network represents a comprehensive attempt to demonstrate a number of educational approaches for young handicapped children. All of the demonstration programs (more than one hundred) in this network have parent programs. The purpose of this monograph is to provide information that will assist you in conceptualizing, planning, and implementing parent programs. Represented in this volume are First Chance projects with exceptionally good parent programs from across the country.

WHY PARENT AND FAMILY PROGRAMS

There are a number of good reasons why these and other projects are attempting to involve parents in their child development efforts. As the numbers of educational programs for young children have increased rapidly over the last few years, there has been a mounting awareness of the need to involve parents in these efforts. Research efforts, such as the work of Gray (1970), Karnes, et. al. (1970), and Livenstein (1970) point out that educational efforts in day care centers, nurseries, Head Start centers, and public schools should be augmented with parent training programs. After an extensive review of the research literature on infant-mother interaction, Streissguth and Bee (1972) conclude that the teaching style used by the mother is very important in shaping early motivation and cognitive functioning.

Unless we develop effective parent programs as a major element of a child development triad of parents, child, and the program, these efforts are destined to only marginal success. During the early years of life, a large proportion of what the young, developing child learns will occur in the child's home environment. The parent, particularly the child's mother or mother surrogate, will be the primary "teacher." This does not change even if the child is enrolled in a substitute care situation such as a day care center.

It is interesting to note that Schaefer (1972) concludes his review of research on the effects of parent training programs by stating that these types of programs do provide an effective supplement or even an alternative for pre-school education. It is logical to assume that unless there is planned consistency between the center's educational program and the experiences taking place in the home environment, the experience provided in the center program may have little effect on the child's development. Communication between parents and program staff is important not only for coordination of training between home and center, but also to provide the staff with valuable information about each child and how he is developing in the home. If parents will relate their observations of the child's behavior in the home to the center staff, more meaningful activities can be planned for the child within the center or school.

It is being more widely acknowledged that the parents of children in child development centers are one of the primary consumers of services. As consumers who are paying for a service, if not through fees then through public taxes, parents should participate in planning activities to assure that they receive the type of services they want. The gap between parents' expectations and the services provided by the center or school must become as narrow as possible through cooperation and coordination.

It goes without saying that parents and program personnel contribute uniquely to the progress of the child. Parent and child interaction must be as productive and adaptive as possible; parents should be encouraged to provide an emotionally warm, secure relationship with their child, and to reinforce positive behavior.

Very often when parents recognize the existence of problems, they have a tendency to focus on those concerns and to ignore the more positive aspects of the child's functioning. In doing this, they may overlook normal aspects of the child's development. When parents notice that a child is having difficulty in accepting appropriate limits or discipline, they may feel the youngster is not developing an adequate respect for authority and may become apprehensive about the possibility of serious consequences during adolescence and later life. They may not notice the times when the child's behavior is quite appropriate or they may not respond to that behavior. To the contrary, they may be constantly on guard for misbehavior and may even set up artificial situations in which they attempt to exert authority.

In most child development programs, there is a lot of similarity between program and parents' needs. Both are concerned with the optimal development of the child in all dimensions—physical, emotional, intellectual, and interpersonal. Both aim at the child's reaching the highest possible level of adaptation. The program needs the parents' cooperation and assistance in a variety of ways; and parents need support, advice, direction, and information from the program personnel. None of this can be accomplished unless there is a close, compatible working relationship between the program staff and the family.

In conclusions there are two general purposes for providing viable parent programs in early childhood education: to improve the center's ability in providing effective services to children through their parents and to provide a supportive system for parents in accepting the role as parent and fulfilling their personal needs as individuals.

DIMENSIONS OF PARENT PROGRAMS

There are at least four major conceptual areas in planning parent programs that you should consider in a precise and systematic manner: supporting parents emotionally, exchanging information with parents, improving parent-child interactions, getting parents to participate in your program. Although the main focus of the delivery system presented in this monograph is on improving parent-child interactions through parent training, it is important to place this vital area in perspective with some other important dimensions.

Social and Emotional Support—The purpose of activities in this area is two-fold: to reduce anxieties caused by guilt feelings and feelings of inadequacy in the family, and to provide socially stimulating activities which increase positive feelings about the family unit as well as the parents' feelings toward themselves as competent parents.

The birth of a child into a family is by itself a potential life crisis. In a discussion of the need to attend to emotional and social needs of parents, Enzer (1973) stresses the potential for crisis in the family and the crucial role the center staff play in supporting the parents as an individual.

As parents strive to fulfill their role successfully there arise many self doubts, resentment of, and confrontations with the child. It is quite evident that one focus in parent programs should be on meeting the parent's emotional and social needs of this kind.

A few parents, because of prior emotional difficulties or lack of emotional support, may be overwhelmed by their feelings. These parents may not be relieved by venting their feelings and may need additional professional help. However, the sincere teacher or child worker who listens carefully can give adequate support to most parents. Often the objective in this area is to increase in the parents a positive attitude toward their role as an educator of their child and perhaps, more important, to increase their feelings about their own importance as a worthwhile human being.

There are many ways to meet social and emotional needs of parents once you have identified what those needs are. Often the activities center around a regularly scheduled meeting of a group of parents. Topics in these meetings may vary from discussing various types of craft activities that parent and child can do together to listening to book reviews or formal lectures from professionals. For the group meetings to be successful it is important that the members of the group indicate to one another through their actions as well as their words that these meetings hold value for them.

Exchanging Information—Activities for parents in this area should lead to the following goals: (1) providing parents with an understanding of the rationale, objectives, and activities of the program in which their child is enrolled; (2) developing an understanding of the continuous growth and development of the child as they apply to the child's interactions in the home; and (3) providing the project personnel with background information on the child to facilitate the effectiveness of the center program. This should include descriptions of the child's activities in the home.

There are many different kinds of information that you can and should be giving parents about the program. Well-thought-out discussions or written information indicating what you hope to accomplish during the year is extremely important to keep the parents' support and interest. For example, the parents should know what kind of changes in their child or accomplishments by their child they should be able to see. When these goals have been articulated well, the parents will then understand the relationship and purpose of the many activities that go on during the year to the intended goals. Periodically parents should be given a preview of the schedule of activities that lie ahead for their child, and at this time the importance of the sequence of these events and the end results should be presented.

Routine information flowing from your program to parents is essential. Scheduling, special events, parent conference schedules, fee schedules (if fees are collected) are examples of routine information that may be changing often. Sometimes this is accomplished through a newsletter, or a form letter, or by a telephone call.

There is a great deal of information that should be received by the center from the parents about the home and child for the sake of consistency between the center's methods and programs and those used in the home. For instance, such information as what the child likes and dislikes, what kinds of things occupy his time at home, what toys are available in the home, what the relationship is between brothers and sisters and the child can be invaluable to the center. Answers to these questions and many others will help the center personnel to understand the child's behavior while he is at the center.

Many programs provide information to parents on child-rearing practices and child development sequences. Often workshops are provided to assist parents in specific areas of child-rearing such as "teaching your child to talk," or "disciplining your child." This kind of information-giving, however, overlaps with what we refer to as parent-child interaction, which we discuss next.

Parent Participation—The purpose of activities in this area is to involve parents in the ongoing activities of the program. The assumption is that by productively utilizing the parents in activities such as being a teacher's aide, the parents' feelings of self-worth will be enhanced. Their understanding of children will increase, and a larger repertoire of experience and activity for the parents to draw upon for interaction with their own child will be developed. Another important purpose for parent participation in the program is to provide needed manpower for the successful functioning of ongoing activities.

Although this area may overlap to some extent with the other areas already discussed, there are a number of program objectives that you may want to pursue in this area alone. Parents need to be involved in some of the basic program decision-making, perhaps as members of an advisory group. After all, the parent is one of the two primary consumers of your services. Parents are also involved in financing the programs through fees or taxes. It is therefore reasonable that the program be accountable to parents in program decisions.

This is not to say that parents should unilaterally make program decisions. On the contrary, the program staff are the trained professionals and should be able to provide viable alternatives for most aspects of the program. Parents will look to the staff for leadership in program decisions and will expect it. In return, the center personnel should expect from them valuable assistance in program decision-making.

For years many programs have found that parents make excellent volunteer aides. Under the direction of the teacher or child worker the parent aide can be involved in such activities as providing learning experiences for children, monitoring and assisting in lunch and snacks, assisting in taking off and putting on heavy wraps, constructing learning materials, and providing transportation.

Usually most groups of parents have some members with special skills, such as carpentry, baking, or storytelling. Other parents may have had interesting jobs or interesting experiences, and they can be utilized as resources for program activities from time to time.

Improving Parent-Child Interactions—The fourth dimension of parent programs is the primary focus of this monograph—training parents to become more effective child rearers.

Activities that you plan in this area should be designed to improve the effectiveness of parents as teachers and "rearers" of their child. The parent, through the years, will be the child's primary source of information. Hence, the parents must be capable of providing meaningful interaction with their child to stimulate cognitive, emotional, and social development.

To facilitate parent-child interaction, your program should provide opportunities for parents to develop skills in (1) general child-rearing practices, (2) promoting and fostering social and emotional development, (3) utilizing and optimizing everyday experiences, (4) fostering and encouraging language growth, and (5) utilizing effectively the community resources available to assist the child in learning activities.

Although perhaps an over-simplification, most programs can be identified as following one of these three models: a behavioral model, a psychological insight model, and an experience model. The behavioral model employs a great deal of what we know about learning and development in a systematic, structured manner. In this approach, the parents are first taught some basic terminology and understanding of reinforcement principles. They are also helped to develop their abilities to observe and quantify, or count, the frequency with which various actions of the child occur. The next step usually involves the parents in observing and counting frequency of behavior as well as in administering various types of positive reinforcers to the child. After it is apparent that these skills have been developed in the parent, there usually follows a long, formal relationship between the program personnel and the parent. Perhaps once a week or at another set time interval, the parent will review with a program specialist the results of his interactions with the child by presenting and discussing the behavior frequency charts which he continually uses. As specific patterns of reinforcement become part of the parent's repertoire, often the charting of behavior is dropped.

A number of behavior modification programs are available today. *Parents as Teachers, A Child Management Program* (1971) is designed to help parents learn to be more effective teachers of their children. *Living With Children* (1968) is another often-used book which details the manner in which parents actually teach their child. The parent training approaches presented in the next chapters have a strong behavioral foundation even though they represent quite different delivery approaches.

The psychological insight model deals with developing an understanding in parents about why children behave the way they do, based on analysis of interactions between parent and child. This approach has been popularized through the works of Haim Ginott (*Between Parent and Child,* 1959) during the last few years. This approach emphasizes solving conflict situations through developing "insight" into the causes of the problem. Many programs use lectures and films on child development or personality development of the child to pursue this model. Thomas Gordon's work in *Parent Effectiveness Training* (1970) is an example of a well-known approach that falls into this category.

Programs following the experience model will concentrate on providing systematic experience for parents to use as a mechanism for interacting with their children. These experiences may be highly focused on an area of development such as the *Teach Your Child to Talk* program (1969), or on an age of development such as *Ways to Help Babies Grow and Learn* (1970). Each of these programs offers activities and suggestions for the parents in providing developmental experiences for their child.

Another recent development in assisting parents in providing positive interactions and experiences with and for children is the toy lending library concept. After a discussion of the developmental level and needs of the child, the parent is given an appropriate educational toy to take home for the child to play with. Usually mini-lesson instructions accompany the toy to the home to give the parent an understanding of how the toy can be used for learning. Periodically the parent will bring a toy back to the center and trade it for another which is geared at a slightly higher level of developmental learning.

Parents as Resources, a group of parents in Illinois, have put together a series of suggested activities to increase the positive interactions between parent and child in the home. They have provided two resource books for parents, *Recipes for Fun* and *I Saw a Purple Cow* (1972). These "recipes" provide many arts and crafts activities that parents and children can do together in the home, emphasizing the use of articles already available in most homes.

DELIVERY SYSTEMS

There are four basic service delivery systems presented in the following pages of this monograph: center based, home-center based, home based, and parent administrated center based. These approaches represent basic organizational and management procedures for the delivery of the content of the program.

The term "center" as used in this volume is a generic one. That is, it represents any delivery system that brings children and parents into a central location. This central location could be a preschool classroom in a public school system or a clinical classroom in a university or private setting. In a center-based delivery system, the parent and family involvement program is often ancillary or "in addition to" the actual intervention activities with children. In the center-based approach, the staff-parent interaction takes place almost entirely at the center. The desired result of these interactions, whether they are in the center or elsewhere, is a positive change in the child's or parents' behavior. In Chapter Two, Dr. Alice Hayden discusses the important management dimensions that you must consider in establishing and operating a center-based program.

Another service delivery system, presented in Chapter Three, addresses a combination of two systems—a home- and center-based project. This approach has elements of both the home- and center-based projects. However, the interaction between these elements represents a need for different organizational procedures than do the two systems when approached separately. In a home-center approach, parent-staff interactions take place both in the center and in the home. These interactions are sequential in nature and call for careful planning and coordination between center and home. Drs. Fredericks, Baldwin, and Grove address these considerations as they draw upon their experience in operating parent programs in Oregon.

Home-based programs rely almost exclusively on providing the educational intervention through the parents to the child. The parent-child interactions in the home environment are the primary targets for change and much of the staff-parent interaction takes place in the home as well. Home-based programs do not provide for grouping of children outside of the home for instruction. Instead, it is an alternative to a center- or school-based program. As in any specific delivery system, there are definite advantages and disadvantages to home-based programs. In addition, there are a number of management dimensions that the center staff needs to attend to that will vary from other types of delivery systems. Chapter Four discusses these dimensions in detail as the author, Marsha Shearer, shares her experiences in helping to develop and operate a home-based program for parents of handicapped children.

In addition to these basic delivery systems there have been some recent efforts in turning the entire management and operation of parent programs over to the parents themselves. This consumer-operated delivery system is yet another model and it varies in a number of dimensions from the three approaches mentioned above. Authors Ron Wiegerink and Vince Parrish provide us with some insight into the factors to be considered if this alternative is chosen. The authors have been with a consumer-operated program in Tennessee for several years which is currently operating quite successfully.

Each of these following chapters will address the following program components: **Rationale.** This section discusses the theoretical and philosophical bases for the approach. **Intake and Screening.** The task of finding parents with specific needs is not an easy one. What criteria should be used to select parents for the program? How do you develop a cooperative spirit with parents? How do you systematically assess their needs? **Service Delivery.** The methodologies used to deliver need-related services to parents and families are discussed in detail in each chapter. What resources are needed for a particular delivery system? What are the constraints? **Liaison**

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and Follow-through. Continuing contact is an important dimension of parent programs that is often overlooked. How do you assure that the intended activities are actually having an impact on children and their parents as a result of earlier services? **Evaluation.** Each of the approaches presented discuss their evaluation procedures. What are the necessary steps that must be taken to determine the degree of success of the program activities?

Programs for young children with special needs cannot afford to exclude parents from their procedures. It is anticipated that this monograph will provide the staff members who are responsible for parent programs with the framework to make decisions as they plan and operate programs for parents and children.

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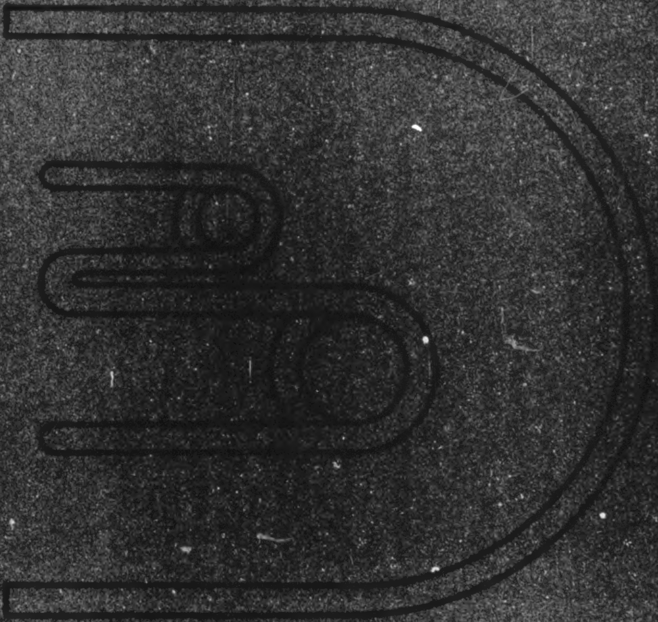
CHAPTER 2



A Center Based Parent Training Model

By Alice H. Hayden

RATIONALE

The degree or extent to which parents and families are involved in providing special services and instruction to young handicapped children varies widely from one program to another depending upon some of the following factors: the administrative organization and purpose(s) of the program, school, or agency; the philosophy underlying the program; the need for direct parent assistance to the children and to the programs; and the goals and objectives of the program.

What are Multidisciplinary Center-School Programs?—A number of universities having medical schools and other resources benefiting retarded and handicapped children recognized early the need to bring many resources together in a Center in order to permit greater exchange among the different disciplines such as medicine, nursing, dentistry, education, psychology, social work, speech pathology and audiology. Such exchange would promote efforts to attack some of the problems of prevention, remediation, and treatment of handicapping conditions. Professionals and representatives of a number of agencies joined hands with parents in presenting their problems and plans for such Centers to the President's Committee on Mental Retardation. Some of the first funding received by such groups was for construction only; that is, for building Center facilities. The Centers at the University of Washington and at Albert Einstein University in New York were the first two such Centers, funded in 1964. Perhaps these Centers are now best known as University-Affiliated Facilities.

The University-Affiliated Program at the University of Washington—The Child Development and Mental Retardation Center at the University of Washington has four component units: Medical Research, Behavioral Research, Clinical Training (and Diagnosis), and the Experimental Education Unit, which has three major functions—training, research, and service to handicapped children and their families.

The Experimental Education Unit School provides instructional programs for handicapped children from birth to eighteen years of age. This chapter will focus on the service aspects of the programs in the Unit's Model Pre-School Center for Handicapped Children. (The Model Preschool Center for Handicapped Children is funded in part by the U.S. Office of Education, Bureau of Education for the Handicapped, under P.L. 91-230, Part C.) The school not only provides instruction for children, but also serves as a demonstration-training facility for university students from many different disciplines, for paraprofessionals in different fields, and for parents who are trained at school to work with their own children at home. Each of the five classrooms for preschool age children serves two groups of children a day; the children are grouped into classes according to age and to the severity of their handicaps.

Because the children spend only two or three hours per day at school, it is essential that parents learn how to help their children develop self-help, motor, communication, cognitive and social skills in the home, where the children spend so much of their time. The different types of parent training and involvement depend upon the particular program the child is in and upon his and his parents' or family's special needs. The focus is always on the child, and on how the staff and the parents can best work together to meet his needs. Those who are working with parents need to recognize that parents' needs are as different and as individual as those of their children.

Parents usually find that, among the many advantages of being trained in the Center, rather than at home, is the opportunity to talk to and work with other parents of handicapped children. Those parents who have children with similar handicapping conditions often develop strong bonds of friendship and are appreciative of the gains made by all the children.

At the Model Preschool Center we do not have a "parent training package." There are several reasons for this. First, our emphasis at the Center is on individualized instruction for every child, and that emphasis extends to staff and parent training as well. Although there are basic principles underlying the training given everyone at the Center, we believe that individual parents and families, like their children, have unique needs and problems, and that to be effective in meeting these individual needs, we must maintain flexible training. Second, our Center is different from most schools where parents play an active role in that children are referred to us for relatively short-term intervention—most children spend from one academic quarter to two years at the Model Preschool Center before returning to placements in their home communities. Further, the children may arrive at any time during the school year. So it is not possible for us to plan a single program that begins in September and ends in June—too many of our parents would be short-changed by such inflexibility.

The one exception to this general pattern of short-term intervention occurs in our Down's Syndrome Programs. Many of the children who participate in these programs are referred to us when they are newborn infants, and they may be entered in the Infant Learning Program as early as two weeks of age. Some of the children in these programs have stayed with us for as long as three years; obviously, their parents have experienced a more typical "parent training program" than most others in terms of continuity and duration.

INTAKE

Parents may apply directly to the Child Development and Mental Retardation Center for counselling or service, or they may be referred by clinics, agencies, private physicians, nurses, psychologists, or school districts. How the parents get to the Center is not important; what happens after they arrive there is. If a child needs help, the staff of the Clinical Training Unit at the Child Development and Mental Retardation Center determine which Clinic within the Unit or team of representatives from different disciplines can best undertake the information-gathering necessary to learn as much about the child's problems as possible. If a child is not receiving services essential to his development or treatment, recommendations will be made for placing him in an appropriate program. The first consideration is given to the services available in the child's home community—where would he be best served, given his age and his handicapping condition(s)? In any case, consultations with personnel from the child's home school district are essential inasmuch as the school district is, or will be, responsible for the child's eventual education in a regular or special education program. An objective of the Experimental Education Unit is to return each child to an appropriate placement in his home community as soon as it appears that he will be ready to function adequately in a school district program. The parents must, of course, supply some of the needed information and must also be involved in any decisions about placement. Parents may be invited to visit various appropriate programs, to talk with their personnel, and to observe the children enrolled. Practical considerations such as transportation must, of course, be taken into account.

When a child is being considered for placement in the Model Preschool Center the Admissions Coordinator informs parents of the opportunities for parent involvement and participation in Model Preschool Center programs, and frequently introduces them to another parent whose child has been enrolled for a while. The parents are invited to visit the program their child will be placed in and to meet the staff if they have not already done so. If the parents are expected to participate in one or more class sessions each week, they are informed of this before the child is admitted, and a time schedule is worked out which will be most convenient for them. Parents are told about the regular parent-staff meetings, usually held at least once a month and in the evening so that both parents can attend. There are also all-school parent-teacher meetings each quarter. In addition the Admissions Officer explains parent consent forms and clearances, available insurance policies, and services which may be provided through the University Hospital at a very modest fee.

When it appears that a child is a candidate for placement in one of the Model Preschool Programs, his needs are discussed at a meeting of the Consultant Advisory Committee. Meetings of this committee are scheduled once or twice a month, depending upon the number of children to be considered for placement. Prior to the meeting, the child's records are reviewed to make certain that all relevant information as well as parental consent and clearance forms are in. Program coordinators or head teachers in the different programs discuss how the child's needs can best be met, what support help is needed, and what arrangements have been made to obtain it. The latter arrangements are usually made by the school nurse consultant. The Admissions Coordinator may also report on the information that has been exchanged with the school district in which the parents live, arrangements for transporting the child, and the date when the child will begin his work at the Unit. Every effort is made to keep the time required for admission procedures as short as possible. If it appears that there may be a delay in placing the child in a program at the Model Preschool because of lack of openings, alternative placements are considered. If a child has to wait until his name comes up on a "waiting list," services that he badly needs can be delayed. For this reason, our "waiting list" is short, and we act to place children in a program as quickly as possible if one of our programs is considered by the referring agency and the Clinical Training Unit to be the most appropriate or only possible placement for a given child.

Parents have the opportunity to ask any questions they may have. A well-informed parent who is involved in the parent training programs is a good public relations person and can be very helpful to other parents of handicapped children in the community. By the time a child is admitted to a program in the Model Preschool Center, the parent is usually eager for information and the assistance which can be provided by the staff. The parent may have collected information about the child's behavior at home which can be very helpful to the staff in initiating his program at the Unit.

For instance, children may have certain annoying or puzzling behavior patterns, or problems which are of great concern to their parents or the family. To give just one example of ways in which parents and staff work together to remediate such problems, parents having children enrolled in any of the Down's Syndrome Programs are asked to list home management goals for their children. The staff then helps in the statement of specific objectives and in determining procedures for the attainment of these goals. The evaluation of progress is on-going and integral to this process. Goals for Home Management are indicated on a form such as that shown in Figure 1.

If a child exhibits behaviors that are annoying, the parent may think that the child engages in these behaviors "all the time." Here at the Center, the staff members try to get the parent to collect information on the actual frequency of these behaviors and to encourage the parent to reinforce the child for his desirable behaviors or approximations to desirable behaviors. Helping the parent realize that the child does some things that please him is an important function of the data collection. No child is "bad" all the time or "good" all the time. Staff and parents can work together to increase the frequency of desirable behaviors and to decrease the frequency of the annoying behaviors. Examples of the usefulness of parent data are included in the section on parent participation in procedures common to all programs.

DELIVERY OF SERVICES

We start with parent training as soon as possible after a child's handicapping condition has been identified. Acceptance of the fact that a child has a handicap is not easy for most parents. While they are going through this period of adjustment the parents usually discover that there are sources of help and that they, the parents and family, have contributions to make that will help the child. In the past, many parents have said that the most difficult time they had with their handicapped child was between the time the pediatrician no longer worked with them on a regular basis and the time the child entered some type of school program. During this period

FIGURE 1

GOALS FOR HOME MANAGEMENT

Dear Parent:

Please indicate one or two objectives in any of the following areas that you would like your child to attain this quarter. Be specific. After you have identified these objectives, we will discuss them with you and will help you plan a program or programs to meet them.

(Please state objectives in terms of child behaviors.)

Gross Motor

1. ______________________________
2. ______________________________

Fine Motor

1. ______________________________
2. ______________________________

Self-help Skills

1. ______________________________
2. ______________________________

Preacademic Skills

1. ______________________________
2. ______________________________

Social Interaction and Language

1. ______________________________
2. ______________________________

Behaviors you would like to increase or decrease

1. ______________________________
2. ______________________________

Please return this form during the first week of school. Thank you.

Sincerely yours,
Val Dmitriev
Coordinator, Down's Syndrome Programs

the parents did not know what they could "do" for their child; thus, they waited and felt useless. The situation is greatly changed today with the many and increasing numbers of preschool programs now available for infants and young children. In these, parents can and do play active roles, thereby decreasing their frustrations.

Support to parents and families while they are recognizing and accepting the fact that they have a child with a handicapping condition must be provided so that the parents do not dwell too much on being burdened and on the questions raised in their own minds and by their relatives or neighbors. There are misconceptions about many types of handicapped children; these misconceptions may cause parents to be embarrassed, to have guilt feelings, and to despair. Parents frequently have questions they are afraid to ask or that they do not know how to ask. The sooner some of their questions are answered objectively and their misconceptions are dispelled, the better it is for all concerned.

Those professionals and paraprofessionals working with parents must keep in mind that the needs of parents and families are as unique and different as those of individual handicapped children. It sometimes takes some "extrasensitive" perception to assess the stated or implied concerns of the parents and to get the parents to feel free to express these. Some parents hesitate to talk about problems related to their having a handicapped child, such as marital difficulties, financial problems, or the well-intentioned but not very helpful comments and suggestions of relatives and friends. To reiterate, some families need a time for adjustment, a time to recognize that they need help; and they need encouragement to seek the assistance that is available.

Perhaps excerpts from two recent publications will express the initial impact on parents of being told at their child's birth that the child is handicapped. In the first example, a minister shares with his congregation the reaction he and his wife experienced.

> Three of the saddest words in the English language are 'we had hoped . . .' They capture some of the deepest pain, loss and disillusionment human beings can feel. . . .
>
> . . . Todd finaly arrived at 7:30 p.m., five weeks premature and weighing in at 4½ pounds.
>
> We were very apprehensive about Todd's progress Saturday, since the first 24 hours are a crucial time for premature infants . . . Then we learned Saturday night that Todd's prematurity was one of our smaller worries. We were told that Todd has Down's syndrome. . . .
>
> We don't see ourselves as unusual or exclusive. We think our experience is representative of the process other parents have gone through in this kind of situation.
>
> Some of you know what it's like to look forward to the birth of your first child with eagerness and anticipation, a child with whom to share your world and your life, and then be told after the birth that your hopes and expectations have just been shattered by some chromosomal accident. It is a grief process because there is real grief over the loss of the child you expected and grief over the devastation of your dreams and hopes. . . .
>
> There were times when we didn't want to believe this was happening to us—times when, as one of our prayers of confession put it, we wanted to 'hold out for better terms.' We could hardly hear, much less speak, the words *mental retardation.* We felt almost overwhelmed, and the future looked very bleak and uncompromising. (Martz, 1974, pp. 34-35)

Another reaction is expressed by the parent of a child in the Down's Syndrome Program in the Model Preschool Center for Handicapped Children. The child was admitted to our program when she was five weeks old.

> When Angie . . . was born 2½ years ago, her mother's reaction was hysteria. Angie was, the doctor said, a mongoloid.
>
> 'I had never even been near a retarded person before,' her mother said. 'I thought, 'Oh, my God, what did I do during this pregnancy that caused this?"
>
> Angie's parents are long since over their shock. 'Pretty soon you just have to get busy,' Angie's mother said . . .
>
> She often is asked to visit new mothers of Down's children in the hospital . . .
>
> 'To be told is devastating, and all the books on it paint such a bleak picture. It's natural to be scared, afraid of pitying the child. We all have a fleeting wish that the child will die. It's a normal, healthy reaction. It's fear of the unknown.' (Mills, 1974, pp. 8-10)

From these two examples of parents' reactions to having a handicapped child, it should be immediately apparent that professionals who are going to work with such parents must start "where the parents are" and must not contribute to the feelings they already have of being overwhelmed. Certainly the professionals will be acutely aware of many things that need to be done for the child. However, the families may be more upset by specific concerns that seem paramount to them—concern about the child's feeding, the possibilities of his having other, associated conditions, and their own perceived inabilty to cope with what they consider to be problems in the day-to-day care of the child in the home.

Indeed, there may be many things parents need to know, but let's start with what they perceive to be their needs and let them discover other ways we can work together as partners. No professional team, no matter how expert, can meet all of the child's or parents' needs at the same time. We who are concerned with child instruction often talk about the child's readiness for certain types of activities. Suppose we also think of "parent readiness" for coping with different problems.

In a multidisciplinary center-school, there are opportunities to work with parents and families of handicapped children in a number of different ways. If we are fortunate enough to be able to work with the child and family soon after the handicapping condition has been identified, we can relieve many parental anxieties and start focusing on the child's problem(s) in those early, crucial months and years of the child's life. Early identification and intervention can prevent many other conditions which compound the child's difficulties. It is easier to start applying procedures that are effective in dealing with certain types of behaviors than it is to have to correct ineffective methods of coping with problems. Frequently, the first step in parent training is to convince the parent of the importance of becoming involved in an early training program. Well-intentioned people may have tried to allay parents' anxieties by suggesting that perhaps the child will "grow out of it." Such suggestions frequently do more harm than good and in most cases they do not allay the parents' concerns. The parents still recognize that "something is wrong" and that they need help in finding out what that something is and what they can do about it. Such suggestions often delay the parents' search for help.

PROCEDURES

Some common procedures are used throughout the Model Preschool Center for Handicapped Children and parents learn how to use many of them. The procedures derive from the basic principles of behavior modification: initial assessment of child needs, on-going assessment and systematic observation, daily measurement of pupil progress, modification of individual programs when data indicate that a child's particular program is not resulting in the expected progress. Data are kept on at least two behaviors at a time for each child; in many cases, particularly where parent or volunteer help is available, data are kept on additional behaviors.

Infant Programs—In working with infants from birth to eighteen months we try to assess the child's needs and the parents' specific concerns. In some cases, we seek assistance from physical therapists, nutritionists, social workers, and other representatives of different disciplines who may be able to provide help and instruction to the individual parent or to groups of parents who have common needs and problems such as feeding children or developing their muscle tone. Normally, the parent will bring the child to the Model Preschool Center at least one day a week. Each parent and child pair receives thirty minutes of individual attention during which the parent is shown how to stimulate the child, to help him to attend to sounds or objects, and to make eye contact with adults. The child's responses are reinforced, as are the parents'. Parents frequently stay on after their session to watch our work with other children and their parents so that they may learn through observation either in the classroom or from an observation booth. We encourage parents to report on the progress of the child at home and to ask any questions they may have. They are invited to call staff members at the school or at home whenever they have questions or special concerns. We want the parents to feel that help is as close as their telephone.

Professionalism must be coupled with humanism in helping parents cope with their needs and the child's needs in these early weeks and months when much support is needed. A parent training class is not the answer to parents' needs for assistance at this point. A class could not move fast enough, and the instructor could not anticipate the needs of a group of parents and plan a program that would accommodate them.

Early Preschool Programs—Children from nineteen months to three years of age participate in early preschool programs. Such preschool programs may last for two hours or more any may be conducted four or five days a week. The daily schedule provides a variety of activities designed to develop self-help, motor, communication, social and cognitive skills. In some programs, the parents work with the staff right in the classroom, and each parent has an opportunity to participate in the program at least one day per week. In other programs, the parent observes the work being done in the classroom and has an opportunity to meet with a staff member to discuss the child's progress and to ask questions about working with the child in the home. Data are collected on child progress in every session of every program. Videotapes offer an opportunity to staff and parents alike to review the work done and the children's responses. Every class session is followed by a staff meeting to which parents are invited if they have participated in that class session. Pupil progress is noted and plans are made for the next day's session.

When children and parents have special needs, special classes may be offered. For instance, parents of deaf children may attend classes to learn English sign language and finger spelling while the children are being taught such skills in the classroom, so that the parents can make use of every opportunity which may help the child acquire language and speech skills.

While the emphasis in this chapter is on the earliest preschool years here at the Center, it should also be noted that the procedures described here are used in the Advanced Preschool, Kindergarten, and Pre-Primary classes at the Center and in all of the Center's field programs. Ours is a demonstration center, offering outreach and technical assistance to a wide variety of field programs; because parent involvement is integral to all programs here at the Center, it is one program component that is heavily emphasized in field programs, too.

Parent Participation in Procedures Common to All Programs—In every program, the staff members work with parents in many different ways. There are numerous parent conferences, parent group meetings, direct parent participation, individual parent instruction, and group parent instruction. Parent groups are instructed in the steps of normal child development in the areas of self-help, gross and fine motor, communication, social and cognitive skills. Emphasis is placed on the parent's understanding of normal development because one of the goals of the Model Preschool is to bring each child's development as close to the norms as possible. However, care is taken to point out the wide range within normal development. Parents learn through observing and charting children's progress in these different areas that children progress at different rates in developing skills. For instance, a child may develop normally in motor and social skills but he may show some lag in communication and in cognitive development. Parents are taught how to apply at home the procedures used in school to help their child come closer to the norm, and the parents learn to keep data on the child's performance at home. In this way, the parents of all children are drawn into a cooperative effort with the school staff to bring each child as close to normal skill development as possible.

LIAISON AND FOLLOW THROUGH

In addition to showing consideration for the individual child and his family and individualizing programs of instruction for both the child and the parents, our staff places emphasis on developing the competence, confidence and independence of the child and his parents. Parents usually feel the need for much supervision at first--they want to be certain that they are "doing the right thing." The staff members reinforce the parents when they have learned what to do. They also make sure that the parent doesn't feel that the child will perform a skill for, or respond to the staff member but not the parent. It is frequently necessary to point out—"See, he did it for you, too." The staff member asks the parent to report what the child does at home. Parents' feelings of insecurity and doubt about their abilities to work with their own children must be dispelled as quickly as possible. Demonstrating that their work is effective is the best way to achieve the goal of parental security and independence in working with their own children.

The following condensed excerpts from Model Preschool case studies illustrate the important roles parents can play as data-takers and behavior modifiers. They also are good examples of ways in which parents and staff work together to remediate a particular problem that the parents or family find worrisome. In both cases, the children's names are fictitious.

The first study concerns Randy, a four-year-old boy whose mother was convinced that her son

27

was always naughty and getting into mischief, that no matter what she did he would not change, and furthermore, that his behavior was worse when she was out of the room. Although his teachers at the Model Preschool agreed that a lot of his behavior was inappropriate, they had noticed some improvement at school. His mother, however, had not noticed any change at home. The staff recognized that simply telling Randy's mother that he had some appropriate behaviors would not change her mind; they reasoned that, if she were to collect data herself, she might have a different picture of Randy's behavior and what could be done to change the inappropriate behavior. She eagerly agreed to a program in which she would collect data over a two-hour period each day.

> . . . Based on the mother's verbal descriptions of what went on in the home, a data form was drawn up. The left hand side was labeled negative child behaviors and had four columns in which the parent could enter 1) each occurrence of an inappropriate behavior, 2) what she did when it occurred, 3) the time, and 4) whether or not she was in the same room. The right side of the page was divided into the same four columns but was labeled positive child behavior. . . . She arrived for her next conference armed with several days' records and some preliminary conclusions that she herself had begun to draw from her data. Most noteworthy was the indisputable evidence that Randy was not all bad. . . .
>
> Prior to the next conference, the teacher found a way to code and display the mother's data [to give] almost instant read-out on the dynamics of each two-hour session. . . .
>
> There was concrete corroboration that Randy wasn't all bad; in fact, he was a pretty good boy much of the time; that her being out of the room wasn't necessarily the SD (discriminative stimulus) for his misbehaviors [and] that she really was doing a pretty good job of reinforcing Randy's appropriate behaviors. Further analysis revealed that the bad behaviors often occurred in clusters that did not cover a long time-span but led the mother to the conclusion that Randy was continuously bad; [also] that the mother was inconsistent in handling Randy's inappropriate behaviors: sometimes she scolded, sometimes she spanked, sometimes she ignored, and sometimes she actually rewarded . . . (Allen, 1972, pp. 251-254)

Randy's mother and the staff continued to work together for several weeks—collecting and analyzing data, using these data as a basis for establishing a program to remediate Randy's behavior. The changes in Randy's behavior and in his mother's ability to deal with it were remarkably good.

The next study concerns four and a half-year-old Leslie, whose problem is dawdling—one that almost all parents must cope with at some time or another.

> . . . As most of us who have worked with parents know, telling a parent what to do to remediate a situation rarely has durable efficacy. Instead, the teacher asked the mother to describe, that is, pinpoint, the times when the child's procrastinating annoyed or angered her the most. Not getting herself dressed for school in the morning was a prime annoyance, for this was the time that the mother was most harrassed. The next question asked was whether Leslie could in fact dress herself. "Of course she can," answered the mother with exasperation, "if she wants to. She just never wants to."
>
> The teacher asked the mother to jot down the time that she gave Leslie the first cue to get dressed as well as each time she checked on her, scolded, helped her, or interacted with her in any way. The final data point was to be the time that the dressing was finally accomplished by whatever means. . . .
>
> The mother had five additional days of data to present at the next conference. A quick perusal indicated three things: 1) most days it was taking Leslie 30 to 45 minutes to get dressed, 2) mother was supplying 6 to 9 prompts and scoldings each day,

> and 3) mother usually ended up dressing the child herself. A couple of questions were in order at this point. One had to do with finding out what the mother considered a reasonable dressing time, and the second to find out if Leslie preferred coming to school to staying home. The mother replied she did not care how long Leslie took to dress as long as she was ready before the school cab driver came. Mother also reported that Leslie was really upset whenever she could not come to school. Armed with this information, the teacher made the following suggestions:
>
> 1. Continue taking data.
> 2. Tell Leslie that if she did not get herself dressed in time for her ride, she would have to stay home.
> 3. Reduce to three the number of contacts made during dressing time. If, when she went into the room, Leslie was making even an approximation to dressing, the mother could give her a bit of assistance and much verbal praise for her efforts. If Leslie was doing something other than dressing, the mother was to turn and walk out without saying a word.
> 4. Give Leslie one final warning about 6 or 7 minutes before the arrival of the cab.
>
> The next day Leslie and her mother arrived at school 15 minutes late. Leslie was teary-eyed, her mother obviously upset. It seemed that Leslie had thrown a super scene over missing her ride and therefore school. She had cried, screamed, pleaded with mother to bring her and mother had finally succumbed. A quick conference with mother followed in which she was counseled that if she really did want to eliminate Leslie's dawdling then she must allow her to experience the negative consequences of dawdling—not getting to come to school—no matter how difficult it might be for the mother for a few days. Within a very few days Leslie was dressing herself much more quickly and continued to do so with only an occasional relapse. (Allen, 1972, pp. 248-250)

Professionals interested in parent training will find an excellent review of procedures such as those applied in our programs in an article entitled, "Using Parents as Change Agents for Their Children: A Review." This article by Claudia A. Johnson and Reger C. Katz (1973) provides an extensive review of the literature on "the use of parents in therapeutic roles [that] has resulted from an explicit technology of behavior modification predicted on the analysis and manipulation of environmental contingencies."

EVALUATION

Parents can be and are taught to be reliable data-takers. However, this takes much time and effort on the part of both staff and parents. In our Model Preschool Programs, we spend 500-600 hours a quarter with parents in the many different types of parent involvement described earlier. The total time spent with parents over the course of a full year (four quarters) will range from 2,000 to 2,400 hours. It is time and energy well invested for both staff and parents in terms of pupil progress. If a child is not making the expected progress, we do not ask, "What is wrong with the child?" or "What is wrong with the parent or the trainee?" We ask, "What is wrong with the child's program, and how can we modify it to ensure that the child's progress can proceed at a reasonable rate appropriate for his age level and handicapping condition(s)?" Continuous measurment and analysis of data provide information for improving programs. The use of videotapes and the preparation of case studies also greatly assist in recording and reviewing training and classroom activities. These are also excellent dissemination forms useful in our many field programs where parents play an essential role in replicating our procedures and in improving programs for handicapped children.

What Do Parents Do for Us and for Others Working with Handicapped Children?—Certainly this chapter would not be complete if it did not include some information about the many ways parents have assisted us in our programs and in furthering other programs for handicapped children and their families. Their contributions take many forms and it is interesting to note that many of the things they do are projects they initiated.

First of all, the parents are helpful in working with children and families who are newly enrolled in our programs. They are enthusiastic about the gains their own children have made and are accepting of and reassuring to the newly enrolled children and their families. They form car pools if necessary to transport children or to come to parent meetings. They bring in items they think will be of interest to other parents or to the children.

They also participate in a Parent to Parent Program, which lets pediatricians know that they are willing to visit and talk with parents who have recently been told that they have a handicapped child. They want other parents to know about the resources that are available to help the child and the family.

Moreover, it was a parent group that was instrumental in working with students from the University of Washington Law School in drafting "Education for All' legislation and in getting support for that legislation. These parents are still interested in seeing that the law is fully implemented and that funds are provided to do an adequate job. They recognize the need for early childhood education and are helpful in getting community support for necessary programs.

Parents working in our classrooms assist in many ways. They learn to apply our procedures in their homes in order to insure continuity in their child's program; they learn to take data both in the school and at home; they encourage other parents to work effectively with their own children; they talk with their neighbors and help to dispel misconceptions about handicapped children. In short, they are supporting the staff and extending the efforts to reach and serve families of handicapped children.

Additionally, the parents respond to the many requests that come to us from other parents, reporters and site visitors for interviews; they participate in site visits; they write articles that may be helpful to other parents; and they participate in panel discussions in university classes and programs, and in workshops. They share our concerns about funding and about extending needed services to greater numbers of handicapped children. If site visitors from funding agencies want to talk with parents, we ask for volunteers from the parents. At the scheduled time—that which is most convenient for the parents—we simply introduce the parents to the site visitors and leave the room, confident that the parents know the program's goals as well as we do. Sometimes the parents sense that we have important visitors and they seek to help even if they have not been asked to do so.

Parents have also been instrumental in establishing programs, particularly infant learning programs, in communities where none had previously existed. They continue to request assistance from our staff when it is needed, and to arrange for some of us to meet with the parents and other members of the communities in which these programs are established. They also work with school districts in urging them to extend programs, and are constantly attempting to reach parents of handicapped children in order to help them learn about the resources that are available to them and their children. They work with established agencies, organizations, and programs in their efforts to disseminate information about what can and should be done in behalf of handicapped children.

Finally, parents have been active in the movement to change legislation so that insurance companies include in their coverage provisions for children with birth defects. In light of the fact that medical and professional treatment can be extremely expensive, parents should have help in defraying such costs. Further, publicity given to such efforts to change legislation helps to alert prospective parents of the need to consider "things that could happen in any family" and to learn more about handicapping conditions that may be evident at birth.

Concluding Statement—In their efforts to provide training and assistance in meeting the needs of parents and families, professionals can learn a great deal from the parents and families themselves. That has certainly been our experience here at the Center, where we see our work with handicapped children as a working partnership with the children's parents and families.

As parents and families from the Center move out into communities and seek to establish new programs for other handicapped children and their families—programs that are badly needed but that are not now provided by any agencies—we applaud their efforts to extend services and feel a deep commitment to help them in this work. This approach may not be an ideal one—that is, some standards that the parents and we would like to set for programs cannot possibly be met initially, and it will take time and a great deal of assistance to arrive at "ideal arrangements." But these are beginning efforts and they are extremely important, for without these programs, many children and families needing special services would otherwise be denied them. There can hardly be a more appropriate "testimonial" to the parents' involvement and partnership than their determination to extend services that they have benefited from to other families. Their interest and their many forms of support are richly rewarding to us all.

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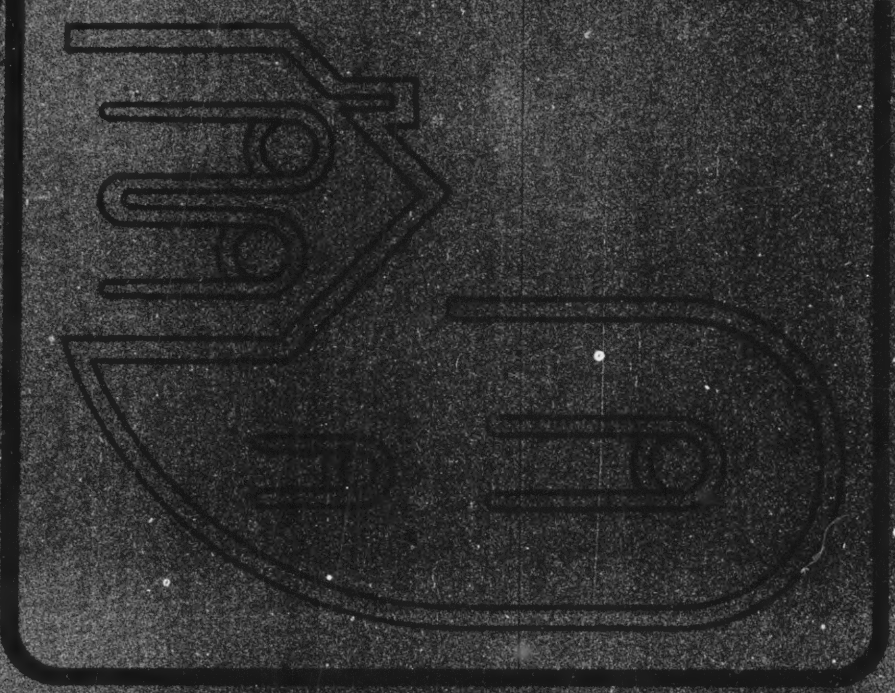
CHAPTER 3



A Home-Center Based Parent Training Model

By H.D. Bud Fredericks
Victor L. Baldwin
David Grove

RATIONALE

Most parent training models are designed to provide training to parents whose children are not enrolled in a program. In fact, many educators take the position that if the handicapped child is enrolled in a school-type program there is little need for the parents to be trained in the techniques of teaching their own child. Two factors militate against this position. First, there is a body of evidence that indicates that if parents of children enrolled in a school or center engage in some teaching of that child, the child's learning will be significantly accelerated. This will be discussed at length later in the chapter. Second, pressure from the parents who want to participate in the teaching of their child often requires that they be taught how to teach their child.

Let us speak to the latter point first. Our experience is that many parents, especially parents of severely handicapped children, are interested in doing as much as they can for their child and consequently are willing to undertake home programs. Moreover, as the child's successes in the center program increase, parents become more eager to want to help their child. Frequently, they have been discouraged about their child's capabilities until the center demonstrates some success with him, at which time the parents' discouragement is replaced by optimism and a desire to contribute to their child's new-found growth. Therefore as educators we need to be responsive to these desires of the parents and instruct them in teaching their own child.

But even if the parents did not request us to provide this type of instruction, it is logical that we should involve the parents in at least some educational activities and training. For instance, it is practically impossible to toilet train a child with only a school training program; a coordinated program between school and home is mandatory if the child is going to be completely trained before he is a teenager.

Perhaps even more critical than the child's acquisition of self-help skills is the acquisition of language skills, which also is accelerated by a home-center coordinated program. Language skills—the acquisition of sounds, blends, words, the chaining of words—can all be learned through structured programs, but it is only with the use of language in the everyday environment of the child that the handicapped child can use language fluently. Since the parents usually constitute a large portion of the child's environment and provide him with much of the feedback he receives each day, it is necessary for the parents to be actively engaged in the handicapped child's language acquisition to maximize the rate of that acquisition.

Certainly for the child to progress through the entire range of self-help skills, the parent must become involved in instructing the child. For example, if a teacher is teaching a child to take off his coat, and the child is required to do as much of that behavior as he is able to at school, it is defeating for the parents to assist the child in taking off his coat at home to a degree greater than assistance is given at school. Development of each of the self-help skills—dressing, self-feeding, personal hygiene—benefits from a very closely coordinated program with the parents.

It is our experience that not only in the areas mentioned above can parents be good teachers, but that they can be effective in any area of instruction. This effectiveness is demonstrated by the acceleration in the rate with which children learn and the quality and quantity of what they learn. In brief, if a parent will conduct for ten minutes to a half hour a day a training program at home in conjunction with the same training program being conducted at the school, the child will acquire the taught skill in a significantly quicker time. In fact the data show that the systematic program involving the parent in conjunction with the school program will almost double the rate of acquisition of the skill. (For a more complete discussion of this acceleration rate see the evaluation section of this chapter.)

This chapter will describe three variations of the Home-Center model which have been used with children who have various handicaps, including deafness and blindness, mental retardation, emotional distrubance and learning disabilities. Thus the model has universal applicability across all handicapping conditions. The three variations of the Home-Center model are: (1) The Lunch Box Data System in which parents conduct instruction at home similar to that being conducted at the school; (2) The Modified Lunch Box System in which parents conduct instruction at home that is not being taught by the school; and (3) the Volunteer System in which parents are volunteer workers at the school and through that experience acquire the instructional capabilities to teach their own child.

THE HOME-CENTER MODEL (THE LUNCH BOX DATA SYSTEM)

Intake—In the home-center model the children are already students in the center and so we shall not discuss how these children are taken into the program. We shall, however, focus on how we take parents into this program.

We think that the parents of every child who is in the program should be given the opportunity to conduct at least one home training program. To start this process a group meeting is held with the parents. They can all be brought together in a large group, or invited to participate in smaller groups according to their child's classroom, by his age, or by his handicapping condition. The purpose of the meeting is to explain

FIGURE 1
TASK ANALYSIS OF THE DRESSING SKILL OF REMOVING PANTS, UNDERPANTS

Steps

1. Child grabs cuffs and removes pants when one leg removed.
2. Child grabs cuffs and removes pants when pulled to ankles.
3. Child pushes down to ankles, grabs cuffs and removes pants when pulled to knees.
4. Child pushes down to ankles, grabs cuffs and removes pants when pulled to thighs.
5. Child pushes down to ankles, grabs cuffs and removes pants.

home training programs and "sell" the idea of participating in a program to the parents. Two major "selling" points have been found to be successful. First, the accelerated rate at which the child can acquire skills should be demonstrated to the parents by specific examples. Second, the necessity for the generalization from center to home of the child's learning, especially in the areas of self-help skills, toilet training and language acquisition, should be stressed.

After this group meeting, individual conferences are scheduled with the parents to determine which program the parent desires to conduct at home. Parents should be encouraged to conduct language acquisition and self-help skill programs if the child is participating in such programs in the center, but they may initially choose a motor program or one in a cognitive area, such as reading or arithmetic. If at all possible the parents' choice should be honored because this choice probably represents their priority of what their child should be taught. It probably also represents skills, which, if the child acquires, will be reinforcing to the parent.

Great care must be exercised in this initial selection of a program. One of the primary considerations in this selection is to choose a program with the parent that is likely to succeed Such as simple self-help skills like dressing, cognitive skills like rote counting, sound recognition, shape sorting and certain motor tasks. It should almost go without saying that we would not pick as an initial skill to be taught one which we have been teaching in the center but with which progress has been slow.

Regardless of which skill we choose, we must further the likelihood of success by breaking this skill into small parts (task analysis) and showing the parents how to teach one part at a time. Figure 1 shows the task analysis for the behavior of removing underpants. If the parents are faced with having to teach only one small step at a time rather than the entire task, the chances for the parents to see some progress are greater and thus the parents will be reinforced for their efforts. Once the program has been selected, the parent is ready to be trained.

Direct Services Delivery—It should be pointed out here that the effectiveness of any parental involvement program is largely dependent on how precise the instructions are that are given to the parents. General instructions will only confuse and frustrate the parents and make them feel guilty when they are not successful. The more specific the program, the less chance there is for failure.

After the program has been selected by the parent and the teacher, the teacher models the program for the parent. During the course of this modeling the teacher demonstrates to the parents all aspects of the teaching paradigm. First, the teacher demonstrates the physical position of the child in relationship to the teacher and the preparation and placement of any cues that may be necessary or materials that may be needed. For instance, when a teacher is demonstrating how to teach a deaf and blind child to take off his socks, the positioning of the teacher and the child is extremely important. The child should be placed in a position sitting on the floor with the teacher behind him, with her legs straddling the child so that she can reach easily over his shoulders if necessary and guide his hands to the socks and through the motions. Likewise, if the teacher is teaching a word recognition program with a child and using picture cards to elicit the words, the placement and the method of presentation of the cards must be stressed and modeled for the parents.

Once the preparation of cues and the placement of the child have been modeled, the teacher must demonstrate precisely the way in which cues are to be given. Imagine a child who is on a program to increase the number of seconds the child attends to the teacher's voice. The preciseness with which the child is told to attend is important. For instance, the cue might be, "Look, Johnny," and if the child were deaf a sign might also be emited by the teacher. The teacher may also desire to touch the child to get his attention initially. All of these fine points of the presentation of the cue must be adequately explained and modeled for the parents by the teacher.

The precision with which cues are given of course is in direct relationship to the severity of the handicap of the child. The more severe the handicap, the more precise must be the cue. The less severe the handicap, the less precision is required in the delivery of the cue although a certain amount of consistency on the part of the parent should be stressed.

The expected behavior that the child is to emit after the delivery of the cue should be explained to the parent. Any shaping procedures that are being utilized or the degree of precision with which the child must emit should all be included in the instruction.

For instance a child is being taught to write the capital letter A. What degree of precision must be expected? Is this correct? Is this correct? or is this correct? Hopefully the teacher has prescribed what degree of acceptability marks success and what is not considered correct. The parent must be willing to accept the teacher's criteria for success. This acceptance will be facilitated by explaining the shaping process—how we first accept a capital A that looks like this: . Then we shall demand that the point of the A start on the line and so we then shall accept anything resembling an A as long as the apex is on the line, such as . Then, we may require the base of the left leg of the A to stop on the bottom line, and so on until we have step-by-step shaped the child's letter-writing ability.

During the modeling stage the teacher demonstrates the way in which to deliver the consequences to the child for the behavior emitted. If the behavior is correct, the teacher demonstrates the way in which to delivery reinforcers, both social and tangible, paying particular attention to the pairing of tangible and social consequences. If signing is required, the delivery of the sign, the verbalization and the delivery of the tangible consequence in rapid succession is a difficult thing to coordinate and must be demonstrated precisely in a set order to the parent.

The method of delivering the negative feedback, or the "No, that is not right, Johnny," when the child makes an incorrect response as well as how to perform a correction procedure, should be demonstrated to the parent. Again, the accuracy of this correction procedure and the speed and precision of the delivery of the consequences are important to the child. The more severely handicapped the child is, the greater necessity there is to deliver reinforcers or negative feedback promptly. The more severely handicapped the child, the more precise the correction procedure must be when the child emits an incorrect response. In order to emphasize the instructions we give to parents of more severely handicapped children, we have the parents read selected portions of *Isn't It Time He Outgrew This?* by Victor L. Baldwin, H. D. Bud Fredericks and Gerry Brodsky (Charles C. Thomas, 1973). All parents are asked to read the initial chapters on cues, behaviors, consequences and data keeping. Additional chapters are read to coordinate with the behavior being taught. For instance, the chapter on dressing would be read if the parents were teaching their child to dress or undress. In addition, there are chapters discussing self-feeding, toilet training, hygiene habits, language acquisition, motor skills, and academic learning.

Once the teacher has modeled the entire procedure a number of times to the parent, the parent is asked to try the procedure with her child in the presence of the teacher. At this point in time, if video tape cameras are available, they can be used to film the parent's attempts and thus facilitate the instructional process. Then, in addition to the feedback given to the parent by the teacher as the program is conducted with the child, the parent can watch a playback of the video tape and more vividly understand the corrections which the teacher has been giving to her. In correcting the parent during the video tape playback, however, emphasis should be placed on the positive aspects of the parents' performance. Too frequently we focus only on the poor aspects.

Once the parent has demonstrated that he or she can deliver the cues and consequences to the child correctly and does so three or four times in a row, the parent is then informed of the extent of the program and the subsequent sequences of the program. For instance Figure 1 shows a sequence for a dressing skill removing underpants. If the child is on step one, the parent is instructed to work on that step until the child makes three correct responses in a row. Then the parent is to move automatically to step two. Perhaps a demonstration of the entire sequence might be necessary at this time.

Since the same program is being conducted in the home as in the center it is important that this program be coordinated between the two environments. Therefore, a data system must be developed for passing information about the child's progress back and forth between the parent and the center on a daily basis. We have dubbed this daily reporting system the Lunch Box Data System. Figure 2 is a data sheet for the dressing program shown in Figure 1 that is passed back and forth between center and home. The instructions to the parents before these data were taken were to move to the next step of the program if the child was able to do a step three times in a row successfully. Figure 2 shows the data as submitted by the parent after fifteen minutes of trying the program at home one evening. The child obviously was able to do step one after a few mistakes and then did step two successfully two times. Therefore, the teacher in the classroom the next day, on receiving these data, will work with the child on step two. Let us suppose for the sake of the example that the teacher achieves success with step two. She then sends home the data sheet to the parent marked as is shown in Figure 3, which indicates to the parent that she is to work with the child on step three. This type of daily communication is imperative if the teacher and the parent are to

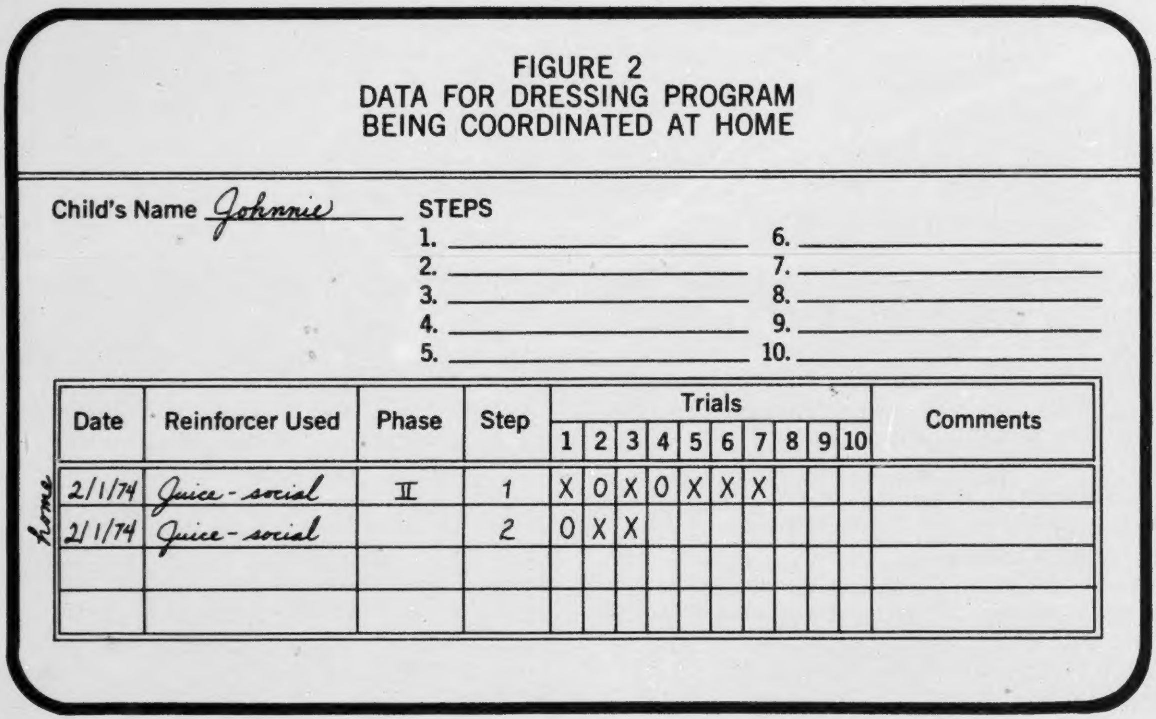


FIGURE 2
DATA FOR DRESSING PROGRAM
BEING COORDINATED AT HOME

Child's Name *Johnnie*

STEPS

1. ____________ 6. ____________
2. ____________ 7. ____________
3. ____________ 8. ____________
4. ____________ 9. ____________
5. ____________ 10. ____________

home

Date	Reinforcer Used	Phase	Step	Trials										Comments
				1	2	3	4	5	6	7	8	9	10	
2/1/74	Juice - social	II	1	X	O	X	O	X	X	X				
2/1/74	Juice - social		2	O	X	X								

coordinate their instructional activity with the child so that there is no lost time in the teaching of this child.

Figures 4 and 5 show two ways in which teachers in two different types of programs provide information for parents about the program which they are conducting. Such directions have been found to facilitate the communication process between the center and the home. Although the teacher has spent additional time modeling, demonstrating and explaining the program to the parents at the center the parents may have some questions when they try the program at home without assistance. These written directions help to answer some of those questions. The amount of detail put into these types of communications varies considerably from teacher to teacher and center to center. Figure 4 shows a home program for a child in the Medford pre-school which caters primarily to children with learning disabilities and educable mentally retarded children, and Figure 5 shows the program sheet that will be sent home together with a sequence for a child in the Teaching Research Multiple Handicap Pre-School.

Liaison and Follow Through—The parent will continue to run the program and data will continue to circulate back and forth between the school and the home. Frequently the parent may experience problems. The parent should communicate these as rapidly as possible to the teacher so that the teacher can take remedial action. Often when the parent has such problems, the parent should be brought into the school to observe teachers modeling and to demonstrate how she is conducting the program at home in order to isolate the problem.

Even if the parent is not experiencing problems with the program, periodic conferences—at least every three to four weeks—are recommended. During these conferences the parent should once again demonstrate how she is conducting the program at home. All teachers sometimes acquire some had habits, and parents are not exempt from this fault. Thus, this periodic conference serves as a maintenance check on the quality of the home program.

One of the center activities that the parents seem to enjoy is periodic parent meetings. During the meetings they share the experiences that they have been having in teaching children. This type of conference is especially valuable for those parents who may be having some difficulties; after listening to how other parents are solving problems, they may be encouraged to try even harder. For parents that are having success, the opportunity to voice that success publicly can be very reinforcing and may help to insure their continuance in the program.

EVALUATION

Evaluation of this kind of program can be done on at least two dimensions. The first is program-wide. What percentage of the parents are participating in this type of program? Our experience indicates that the average center will have about fifty percent of their parents actively running home programs. Of this fifty percent about one-fourth will require rather close monitoring and frequent liaison on the part of the teacher. The teacher should not become discouraged if certain parents refuse to participate in this program or if certain parents who initially agree to participate drop out. It would be an extraordinary program which had more than sixty

FIGURE 3
DATA FOR DRESSING PROGRAM BEING COORDINATED AT HOME AND SCHOOL

Child's Name Johnnie

STEPS

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

	Date	Reinforcer Used	Phase	Step	Trials										Comments
					1	2	3	4	5	6	7	8	9	10	
home	2/1/74	Juice-social	II	1	X	0	X	0	X	X	X				
	2/1/74	Juice-social		2	0	X	X								
school	2/2/74	Juice-social		2	0	X	0	X	X	X					
	2/2/74			3											

percent of the parents participating on a continuing basis in this type of home program. The teacher should strive to prescribe some modeling and instruction to all parents and have the parents demonstrate how they would provide the instruction. Much of this procedure learned by the parent can be used even though it may not be on a consistent, daily basis.

Another way to look at program evaluation is the number of programs which each parent conducts. All participating parents should be conducting at least one program nightly, although it is not unusual to find some parents who will conduct three or four nightly.

A final dimension upon which the value of this kind of home-center program can be judged is the progress of the children. Figures 6 and 7 show graphs of childrens' progress in this type of program. Figure 6 shows a Downs Syndrome child who was first taught to read sight words in the center only. This method of teaching was followed by a coordinated home and center pro-

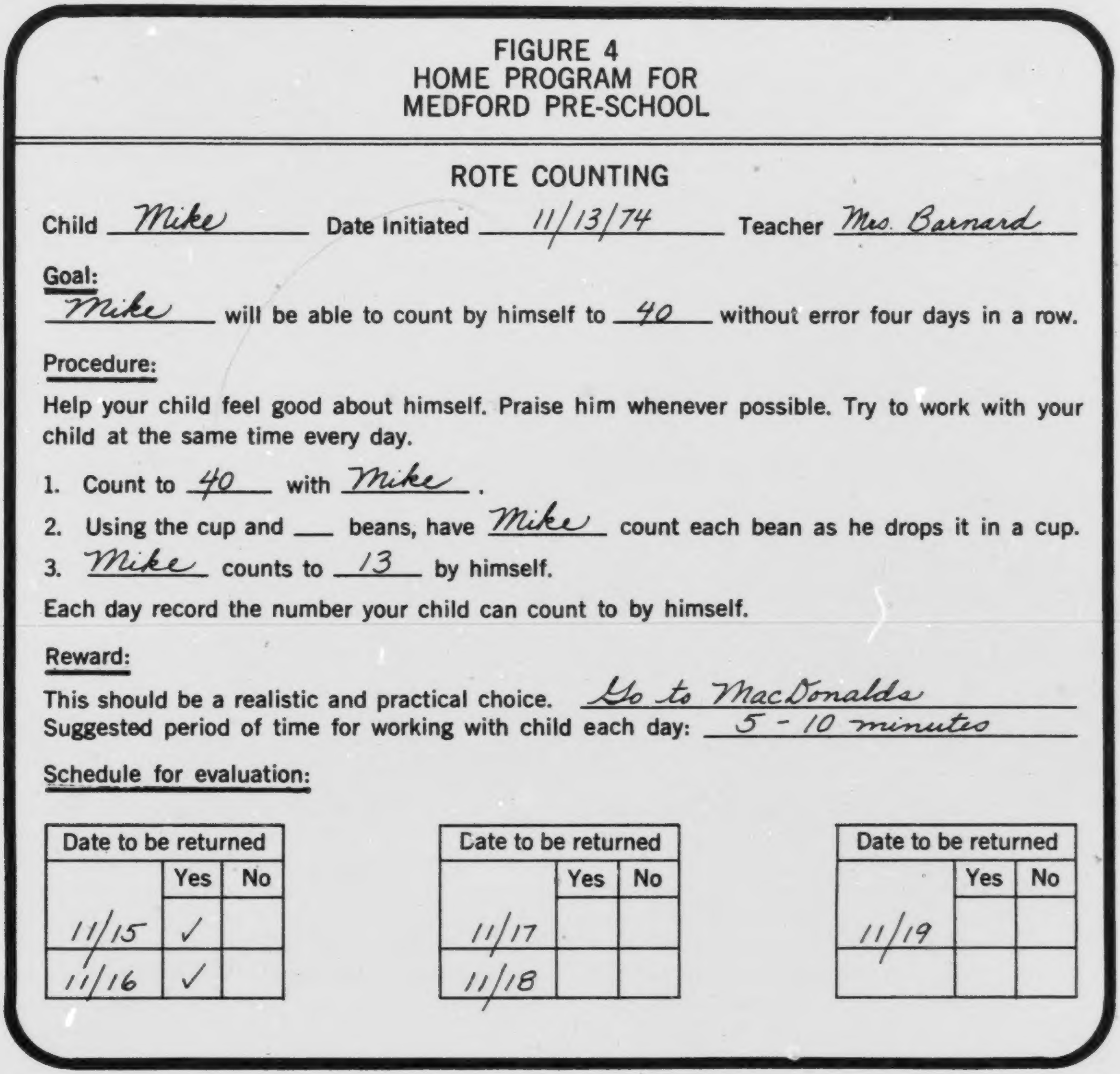


FIGURE 4
HOME PROGRAM FOR
MEDFORD PRE-SCHOOL

ROTE COUNTING

Child Mike Date Initiated 11/13/74 Teacher Mrs. Barnard

Goal:

Mike will be able to count by himself to 40 without error four days in a row.

Procedure:

Help your child feel good about himself. Praise him whenever possible. Try to work with your child at the same time every day.

1. Count to 40 with Mike.
2. Using the cup and ___ beans, have Mike count each bean as he drops it in a cup.
3. Mike counts to 13 by himself.

Each day record the number your child can count to by himself.

Reward:

This should be a realistic and practical choice. Go to MacDonalds

Suggested period of time for working with child each day: 5 - 10 minutes

Schedule for evaluation:

Date to be returned		
	Yes	No
11/15	✓	
11/16	✓	

Date to be returned		
	Yes	No
11/17		
11/18		

Date to be returned		
	Yes	No
11/19		

FIGURE 5
HOME PROGRAM FOR TEACHING RESEARCH
MULTIPLE HANDICAP PRE-SCHOOL

Name: Susie Date started: 1/25/74 Date completed: ________

Task objective: Child will imitate 2-3-4 word chains.

Materials and Setting: objects and/or pictures of the words you're working on.

Treatment:

I. Cue or instructions:

A. Verbal: "Look, Susie, say ________."

B. Non-verbal: Present picture or object as you say the phrase.

C. Incorrect response: "No, Susie."

Criterion level of acceptable behavior: 5 consecutive correct responses before going on to next word chain.

gram. The data demonstrate that after the home and center program was initiated the child's progress accelerated rapidly. Figure 7 shows a graph of a child who is learning to rote count in a learning disability pre-school; the data indicate that after the parents became involved in conducting home programs and helping the child to learn to rote count, the acceleration of his skills was quite rapid. Although these kinds of data have been replicated frequently in this type of home-center program, the evaluation which each center must undertake of this type of program must be on an individual basis, monitoring each child's progress very carefully. The Lunch Box Data System allows that kind of monitoring and evaluating.

MODIFIED LUNCH BOX SYSTEM

In the modified Lunch Box System the home-center model as previously described is followed except that the parent conducts programs with the child that are not conducted at the school. Another term for this model might be the supplementary or modified Lunch Box Model.

Intake—Again children are already in the center receiving instruction. This model is usually initiated when the parent approaches the teacher and states that she would like to work on a program at home which is not being conducted in the center. This request should immediately cause the center to examine the programs which they are conducting with the child, for if the parent is placing such a high priority on this additional program, perhaps the program should be conducted at the center. However, often this is not possible; the problem is manifested only at home.

Delivery of Direct Services—In the Lunch Box Model, the collection of baseline data is part of the routine data-gathering system within the center. However, in the Modified Lunch Box Model, no baseline data have been gathered in the center and therefore the first step in this modified approach must be to gather such data. If the information to be gathered has to do with the acquisition of a skill, it should be easily collected at the center. If an inappropriate behavior is being manifested in the home, baseline data will have to be gathered there. The parent then will have to be instructed how to do this. For instance, let us suppose that the child is exhibiting temper tantrums in the home but not in the school. For baseline data the teacher may request the parent to count the number of temper tantrums and the length of each temper tantrum over a three-day period.

Once the necessary baseline data have been gathered, the procedure for conducting and monitoring the program is essentially the same as the Lunch Box System, except that since the program is not being carried out in the school as well as at home, it is not necessary for the teacher to monitor the data daily, although the parents may request that the teacher do so. Data submitted every three to five days by the parent should be sufficient for the teacher to modify the program as necessary to insure that the child is making progress.

It should be recognized that if this modified program requires the parent to teach the child a skill, the teacher should demonstrate it for the parent and carry out the entire modeling procedure described in the Lunch Box Model. Furthermore, the teacher's written instructions for the parent should be very specific and precise. If the parent decides to deviate in any way from those instructions, the parent should be asked to consult the teacher.

Liaison and Follow Through—Periodic liaison is maintained with the parent on a three-to-five day basis and the programs are modified based on the data at that time. Certainly if the parent is having difficulty she should feel free to call or to contact the teacher and arrange for a conference so as to make early modification of the program.

Evaluation—On a program-wide scale the number of these types of programs should be tracked and examined to determine that there are no deficits in the center programming for the children which

CP 44

EXPRESSIVE LANGUAGE SKILLS

Imitation of Two, Three and Four Word Chains

Phases: I. Child imitates last word of phrase chain.
II. Child imitates last 2 words of phrase chain.
III. Child imitates 2 words of phrase chain picture or object presented.
IV. Child imitates last 3 words of phrase chain.
V. Child imitates 3 words of phrase chain picture or object presented.
VI. Child imitates 4 words of phrase chain.
VII. Child imitates 4 words of phrase chain picture or object presented.
The following are examples of phrase chains to be used when teaching this skill:

Steps: A. Two word chain

1. a boy
2. a girl
3. a shirt
4. the dress
5. the milk
6. the cake
7. a bed
8. a chair
9. red ball
10. a car
11. the dog
12. the cat
13. a house
14. a boat
15. a baby
16. the candy
17. red wagon
18. a toothbrush
19. is eating
20. is washing
21. is writing
22. is dancing
23. is running
24. is sleeping
25. is ironing

B. Three word chains

1. is a boy
2. is a girl
3. is a shirt
4. is the dress
5. is the milk
6. is the cake
7. is a bed
8. is a chair
9. the red ball
10. is a car
11. see the dog
12. see the cat
13. is a house
14. is a boat
15. is a baby
16. is the candy
17. the red wagon
18. have a toothbrush
19. man is eating
20. woman is washing
21. boy is writing
22. girl is dancing
23. boy is running
24. man is sleeping
25. woman is ironing

EXPRESSIVE LANGUAGE SKILLS

Imitation of Two, Three and Four Word Chains (continued)

Examples of phrase chains (continued)

C. Four word chains

1. This is a boy.
2. This is a girl.
3. This is a shirt.
4. This is the dress.
5. This is the milk.
6. This is the cake.
7. This is a bed.
8. This is a chair.
9. See the red ball.
10. This is a car.
11. I see the dog.
12. I see the cat.
13. This is a house.
14. Ride in a boat.
15. This is a baby.
16. This is the candy.
17. See the red wagon.
18. I have a toothbrush.
19. The man is eating.
20. The woman is washing.
21. The boy is writing.
22. The girl is dancing.
23. The boy is running.
24. The man is sleeping.
25. The woman is ironing.

* Work with a group of 3-5 words at a time, spending a few minutes on each word and going over several word chains in each session. Give phrase; Susie must imitate phrase; do not let her give "jargon" before she imitates phrase.

necessitate these additional programs in the home. On an individual child basis, however, the data should indicate the progress of the child and how well the program is working.

One case study of a child on a modified Lunch Box System follows. It illustrates how a center should keep individualized data. Figure 8 shows data for a family whose child is in the Teaching Research Infant and Child Center multiple handicapped classroom. The parents were having difficulty with the child's responding to commands or instructions. In fact, the child's compliance rate was so low that the parent suspected that the child might have a hearing deficit. Yet, the center was not experiencing a similar difficulty. When the child first entered the center, the first few days were spent bringing some inappropriate behaviors under control, but there was no continual difficulty with compliance.

Consultation was held with the parent about the difficulty she was experiencing at home. Baseline data indicated that the child was complying 40% of the time.

A program was initiated in which the parent was required to exaggerate the consequences for the child's compliance and for non-compliance. At the time of this writing, the program is continuing but the compliance rate at home has reached 82% and the parent is in the process of fading the primary reinforcers used in the program (see Figure 8).

THE PARENT AS A VOLUNTEER

Intake—Oftentimes parents are willing to serve as volunteers in the child center. Every opportunity should be made to utilize these parents in the actual instruction of children because, as they learn how to instruct children in the center, the parents will then be able to instruct and guide their own child in the home more effectively. It is a rare parent who works in an effective child center who has not learned to present cues

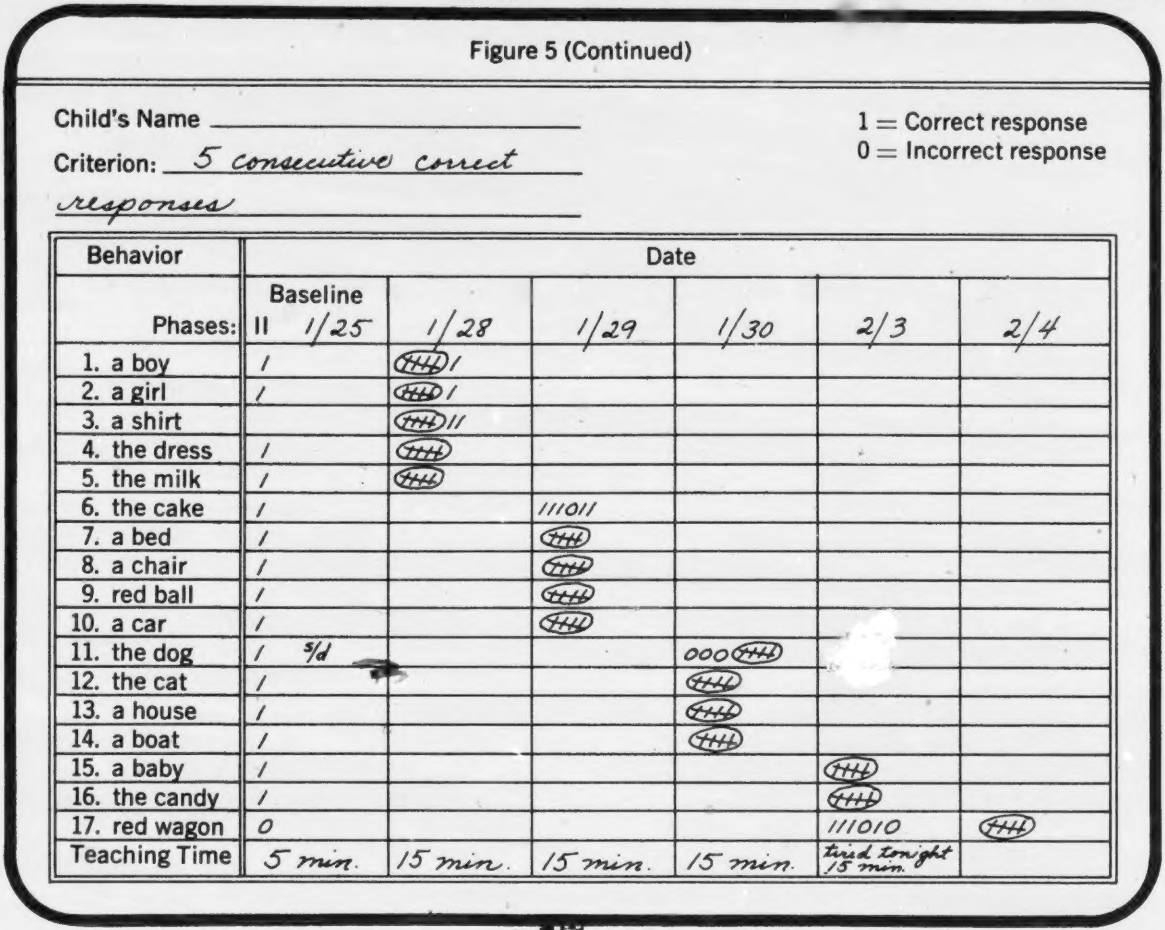


Figure 5 (Continued)

Child's Name ______________________

Criterion: 5 consecutive correct responses

1 = Correct response
0 = Incorrect response

Behavior	Date					
Phases:	Baseline II 1/25	1/28	1/29	1/30	2/3	2/4
1. a boy	/	𝍸 /				
2. a girl	/	𝍸 /				
3. a shirt		𝍸 //				
4. the dress	/	𝍸				
5. the milk	/	𝍸				
6. the cake	/		111011			
7. a bed	/		𝍸			
8. a chair	/		𝍸			
9. red ball	/		𝍸			
10. a car	/		𝍸			
11. the dog	/ s/d			000 𝍸		
12. the cat	/			𝍸		
13. a house	/			𝍸		
14. a boat	/			𝍸		
15. a baby	/				𝍸	
16. the candy	/				𝍸	
17. red wagon	0				111010	𝍸
Teaching Time	5 min.	15 min.	15 min.	15 min.	tired tonight 15 min.	

and consequences properly, who has not learned to analyze a task, and who has not seen the necessity for the maintenance of data to insure more efficient programming of children.

A group meeting of parents might be held to obtain volunteers. The topic of parents' volunteering should be presented and explained. The presentation of video tapes of parents at work in the center is particularly effective. Emphasis on the benefits that will accrue to their own child may "sell" some parents on the idea.

Service Delivery—Once the parents have agreed to volunteer, they must go through a training period. The limits of this chapter do not allow a

Figure 5 (Continued)

Child's Name ____________

Criterion: 5 consecutive correct responses

1 = Correct response
0 = Incorrect response

Behavior	Date				
	2/3	2/4			
a toothbrush	001	𝍸			
Susie is eating	𝍸				
Susie is washing		100𝍸			
Susie is writing		1110101			
Susie is dancing					
Susie is running					
Susie is sleeping					
Susie is ironing					
Teaching Time	15 min.	15 min.			

FIGURE 6
PROGRESS OF A CHILD IN A HOME-CENTER PROGRAM

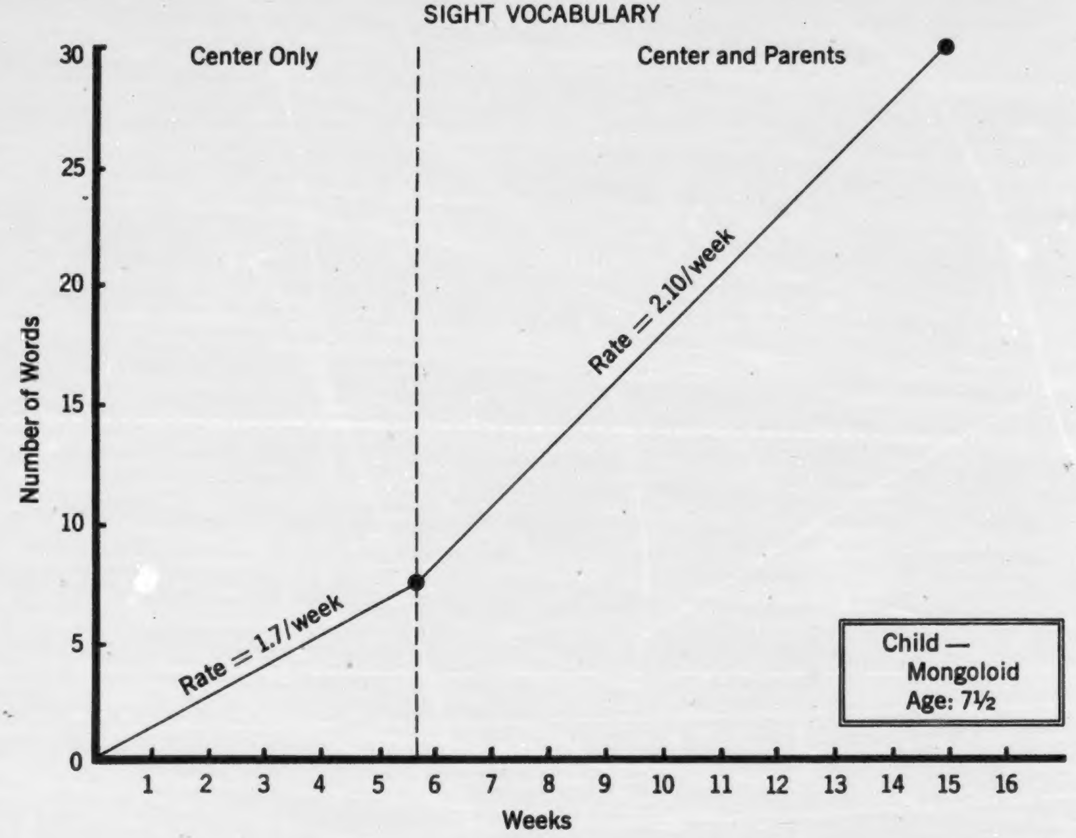
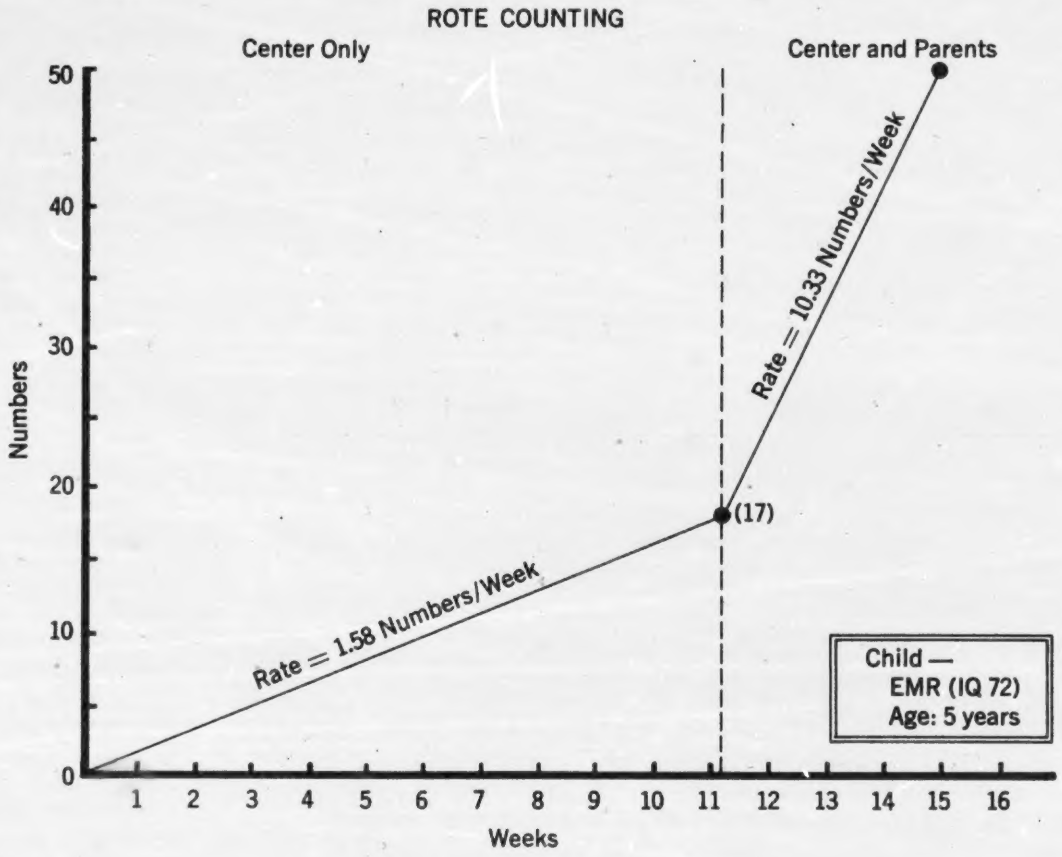


FIGURE 7
PROGRESS OF A CHILD IN
A HOME-CENTER PROGRAM



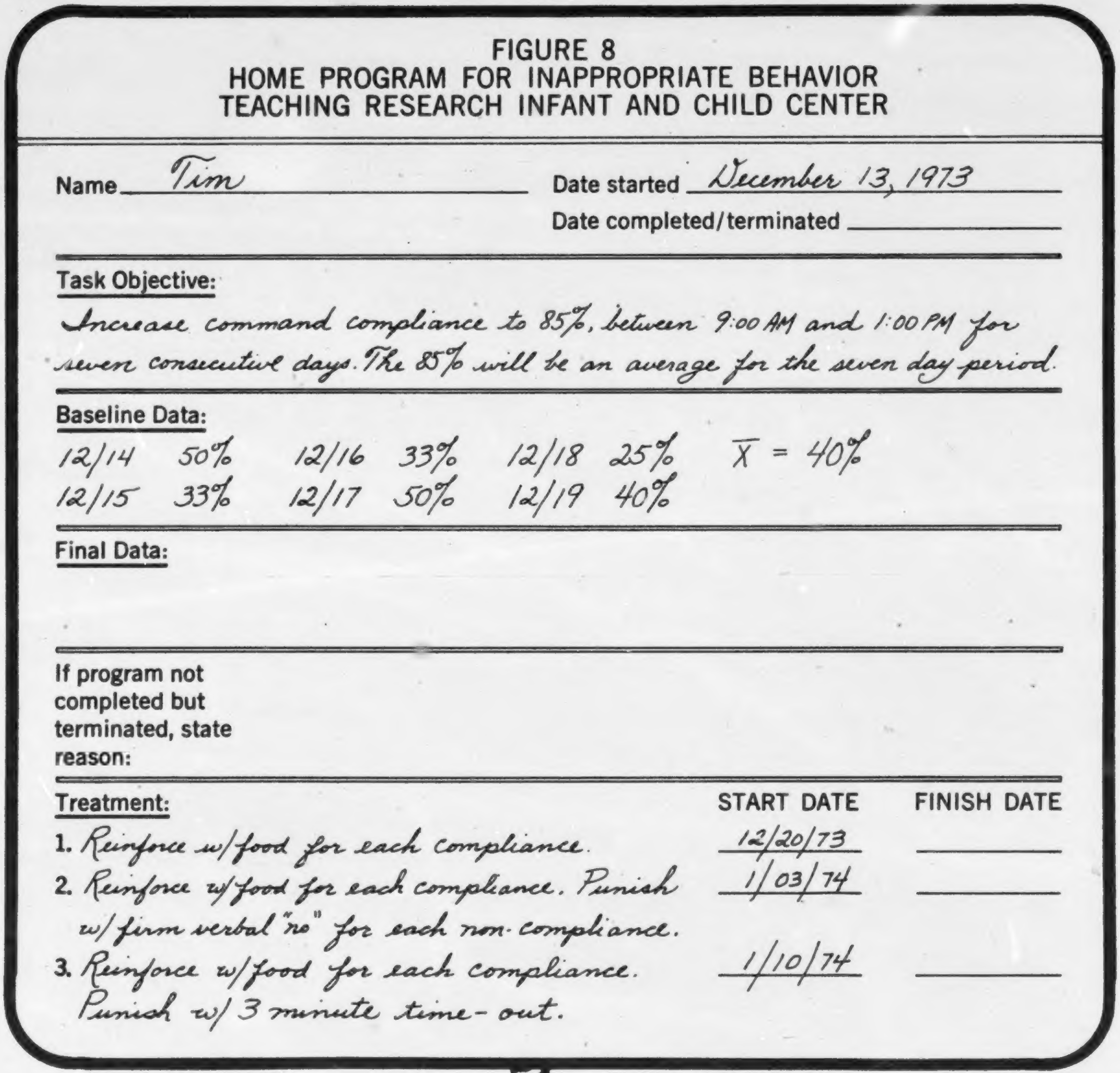


FIGURE 8
HOME PROGRAM FOR INAPPROPRIATE BEHAVIOR
TEACHING RESEARCH INFANT AND CHILD CENTER

Name Tim
Date started December 13, 1973
Date completed/terminated ______

Task Objective:

Increase command compliance to 85%, between 9:00 AM and 1:00 PM for seven consecutive days. The 85% will be an average for the seven day period.

Baseline Data:

12/14 50% 12/16 33% 12/18 25% $\overline{X} = 40\%$
12/15 33% 12/17 50% 12/19 40%

Final Data:

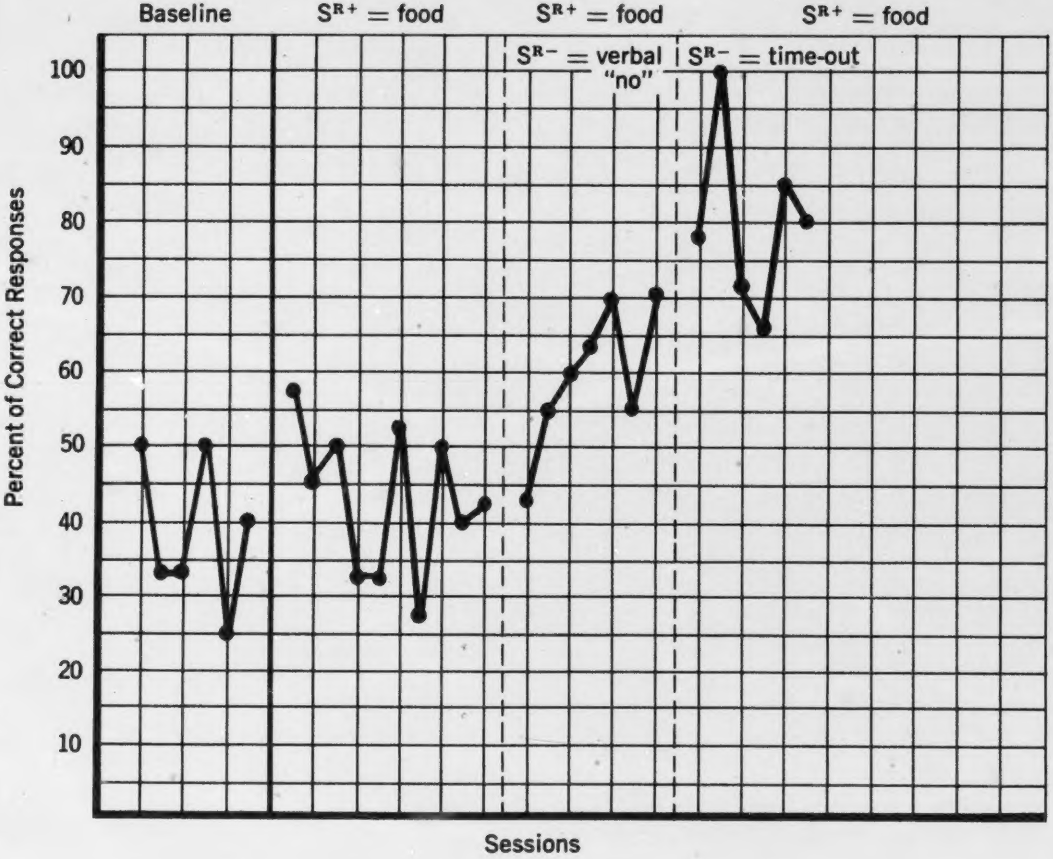
If program not completed but terminated, state reason:

Treatment:	START DATE	FINISH DATE
1. Reinforce w/food for each compliance.	12/20/73	
2. Reinforce w/food for each compliance. Punish w/firm verbal "no" for each non-compliance.	1/03/74	
3. Reinforce w/food for each compliance. Punish w/3 minute time-out.	1/10/74	

FIGURE 8 (Continued)

Child's Name *Tim*

Program
Initiated *December 14, 1973*
Terminated



complete discussion of the training that should be conducted for a parent volunteer. However, we have found certain rules for training to be effective guidelines. In short, some of these guidelines are:

- Time must be taken to train volunteers and the training must be concise and simple. A short lecture describing the center, the things a volunteer must do, and some principles of teaching is an excellent way to begin. This lecture is followed by observation and demonstration, and finally, the volunteer should be placed in a practicum situation in which he teaches children under supervision of a teacher or an aide.
- Volunteers must be given teaching tasks in the classroom comparable to their level of training. It will take time for parents to learn how to teach all parts of the curiculum. Starting them in one area—such as self-help, motor, development, or arithmetic—will allow them to master that area before they are required to teach in another.
- A continuous system of feedback as to the adequacy of the volunteers' performance must exist. To do this the center must have a system of observing volunteers that allows center supervisory personnel to monitor the quality of the volunteer's teaching and to give feedback to volunteers.
- A simplified system of communication between the teacher and the volunteer that does not require oral instruction must exist. The teacher should write down specified, detailed directions on how instruction is to be delivered to children. It further requires that the volunteer record the performance of the child in some systematic way, and that the recorded data be examined on a regular basis by the teacher in order to provide timely updating of children's programs.
- A system of flexible scheduling of volunteers must be maintained. The center must be prepared for volunteers to miss days.
- The scheduling must allow for that possibility. It must also accommodate the training level of the volunteer.

For a more complete discussion of the guidelines, see *A Data Based Pre-School for the Multiple Handicapped* by H. D. Bud Fredericks, Victor L. Baldwin, David Grove, William Moore, Charles C. Thomas, in press.

Liaison and Follow Through—Ideally, once the parents have learned these skills of teaching in the center, it would seem that they should also be able to take those skills and utilize them in the home with their own child. If such a parent is not already conducting home programs, every effort should be made to encourage her to do so. She is then ready to move into the Lunch Box Data system.

Evaluation—Evaluation of parents' participation as volunteers can be done on two dimensions. First, program-wise, a simple count of how many parents volunteer is useful. Certainly we would expect at least twenty-five percent of the nonworking mothers to volunteer at least one day a week in the center.

The other dimension upon which the effectiveness of parents as volunteers can be measured is their success as teachers, which can be measured by tabulating their efficiency in dispensing cuses and consequences, and the way in which they keep data and help manage the children.

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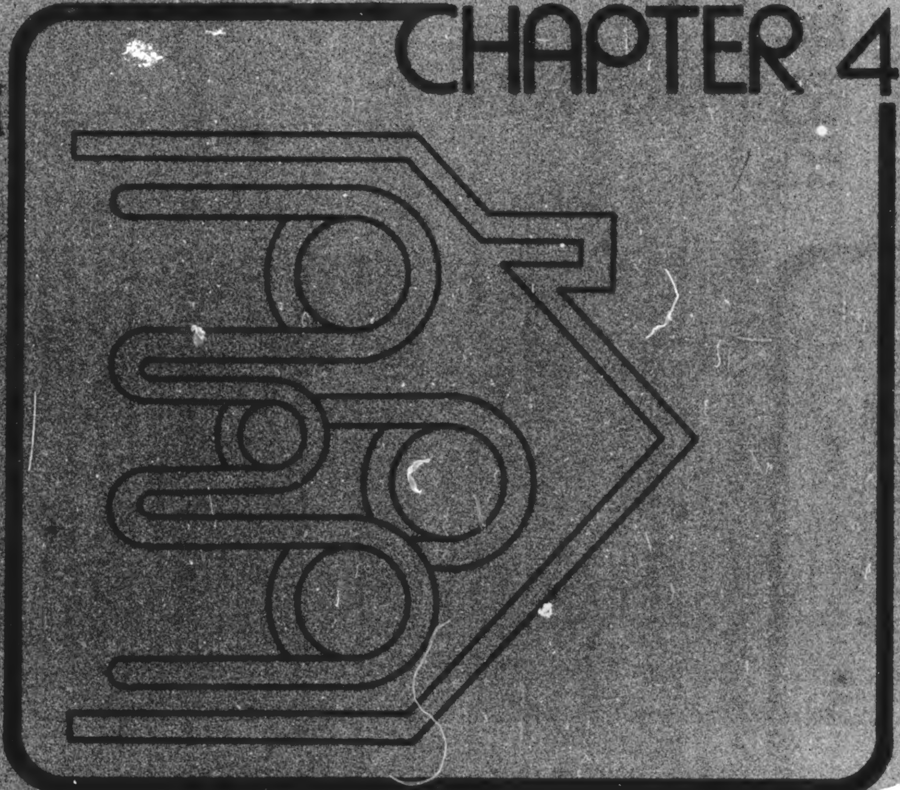
CHAPTER 4



A Home Based Parent Training Model

By Marsha S. Shearer

The basic operational premises of the Portage Project, as they relate to parents are:

1) Parents care about their children and want them to attain their maximum potential, however great or limited that potential may be.
2) Parents can, with instruction, modeling, and reinforcement, learn to be more effective teachers of their own children.
3) The socio-economic and educational or intellectual levels of the parents do not determine either their willingness to teach their children or the extent of gains the children will attain as a result of parental instruction.
4) The precision teaching method is the preferred learning model since feedback is provided daily to parents and weekly to staff, thereby reinforcing both when goals are met. Moreover, the method provides a continual data base for curriculum modification thus maximizing the likelihood of success for parents and children.

OVERVIEW AND RATIONALE OF THE HOME BASED PROGRAM

The Portage Project operates administratively through a regional educational agency serving twenty-three districts in south-central rural Wisconsin. The Project presently serves 140 children, birth to school age, who have been identified as being handicapped in one or more developmental areas. Any preschool child, with any type or severity of handicap residing within the 3,600 square mile area served by the agency, qualifies for the early intervention project.

In the Portage Project there is no classroom program. Instead of having children come into a center, we use "home teachers" to visit in every child's home where they instruct the child's parents how to teach their own child. So our model is completely home based, rather than center based and parents with the help of home teachers do all the teaching of their own children.

Three practical factors influenced our decision to have an exclusively home-based program. The first was that we were dealing with such a large geographical area that the cost and responsibility of transporting very young handicapped children great distances was prohibitive. Second, even when several children were identified within a smaller geographical area, such as one school district, the variance in chronological ages, functioning levels, and handicapping conditions precluded the possibility of establishing classroom programs. Finally, classroom programs would have severely limited parent involvement because of the geographical and psychological distances between home and school. On the basis of these factors we decided that all instruction would take place in the parent and child's natural environment—the home.

To implement this program, a home teacher is assigned to each child and family. This educator, who may be a trained professional or a trained paraprofessional, visits each of the assigned fifteen families one day per week for one and a half hours. Individual curriculum is prescribed weekly based on an assessment of each child's present behavior in the areas of language, self-help, cognitive, motor, and social skills. Utilizing the parents as teachers, the Portage Project follows the precision teaching model which is comprised of these elements:

At least three behavioral goals are selected for the child to learn each week. The goals and criteria for accomplishing them are chosen so that the child, and thus the parent, will achieve success within a one week period of time.

Baseline data is recorded by the home teacher on each new task prior to instruction to the parent as an additional check on the readiness of the child to proceed with other learning activities.

The parents implement the actual teaching process itself, including reinforcement of desired behavior and reduction or extinction of behavior that interferes with learning appropriate skills.

The home teacher records post-baseline data one week after the baseline is taken to determine if the prescribed skills have, in fact, been learned.

The purpose of the weekly home visit is to instruct the parents what to teach, how to teach, what to reinforce, and how to observe and record behavior. The home teacher instructs the parents (or siblings or parent substitute) during the home visit. Then, the parents or substitute teach the child and record his progress daily throughout the following week.

In this model there are certain practical advantages—not having to transport children or provide a center facility—that reduce the cost of the program by more than half. But even more importantly, there are inherent advantages that the Portage Project staff has experienced in the home-based, precision teaching model. These advantages are based on involving the child's first, and potentially his best teachers—his parents. The educational assests that we found are:

- The parent teaches the child in their natural environment. Therefore, they do not have the problem of transferring learning into the home as they would if the child were in a center-based program.
- This model is totally dependent on parent involvement for success. Since one and a half hours one day per week is not a sufficient amount of time for a child to learn developmental skills from the home teacher, parents must be taught to teach

their own child between home visits. Thus, training parents is more than an adjunct—it is absolutely mandatory.

- Another major advantage in using the home-based precision teaching model is that the home teacher and the parents have direct access to the child's behavior as it occurs naturally. This situation engenders realistic curriculum goals that will be functional for the child within his unique environment. In fact, the differences in cultures, life styles, and value systems of parents are incorporated into curriculum planning, since the parents determine what and how their child will be taught.
- It is more likely that the skills that the child learns will generalize to other areas and be maintained if the skills have been learned in the child's home environment and taught by the child's natural reinforcer—his parents.
- Father, sibling, and extended family involvement becomes a realistic and obtainable goal. When instruction occurs in the home there is more opportunity for full family participation in the teaching process.
- There is access to the full range of the child's behavior, such as temper tantrums which only occur in the home or hearing from the parents that their child is crawling into bed with them each night. Much of this behavior could not be targeted for modification within a classroom.

Finally, since the home teacher is working on a one to one basis with the parents and child, individualization of instructional goals for both is reality rather than an idealized goal.

PARENT PARTICIPATION IN THE INTAKE AND ASSESSMENT PROCESS

After a child has been referred to the Project, (parents can and often do refer their own children) a home teacher contacts the parents and makes an appointment to visit the home to explain the project and meet and screen the child.

It is at this time that parents are told that they will teach their own child and that they will learn how to teach him by observing the instruction given by the home teacher. The following are examples of a few typical reactions of parents and resultant responses of the home teachers at this point.

- Parent: "Oh, I've tried teaching Mary, like how to walk, but she can't even crawl yet."
  Teacher: "Maybe teaching Mary how to crawl, if she's ready, would be a good place for us to begin."
- Parent: "We're not trained teachers; we can't do anything as important as that."
  Teacher: "You've been teaching Jim all along. Just look at all the things he can do. He makes sounds, he's beginning to feed himself, he matches objects, he points to body parts. You've taught him a lot!"
- Parents: "We've given up trying to accomplish anything. He just drives us crazy. You teach him and leave us out of it."
  Teacher: "I can't. I need you and so does Chris. While I'm here, I'll show you what to do and how to do it. I'm not going to ask you to try anything without showing you first that it's going to work. So let's give it a try together."
- Parent: "Oh, I don't have time to teach Todd."
  Teacher: "You do spend some time with

Todd each day don't you? Okay, all I'm asking is that you spend that time working on these activities. I promise they won't take more than half hour a day. And yell any time if you think it's too much."

- Parent: "I have no patience. I don't think I can do it."
  Teacher: "Sure you can, I'll give you all the help you need. Give the program a try for a month or so. If you don't think we're getting anywhere, you're free to withdraw at any time. But give it a try first."
- Parent: "I work all day, don't get home 'till 6:00 and by then I'm exhausted. I fix dinner for Dawn then she goes to bed. There's just no time for me to work with her."
  Teacher: "I'll be happy to work with Dawn's babysitter and I'll call you each week to keep you posted so you'll know how she's doing and what to work on during the weekend."

But the most frequent reaction to our approach to parents is, "We've never gotten any practical help 'till now. Every time I take her in for an evaluation, we're told nothing. Oh, they tell us Penny will never walk and that she might be blind. But no one has ever told us what we can do to help."

After five years of working with nearly four hundred parents, we have found that the most frequent question asked during the initial visit is, "What can I do with my child; how can I help him learn?" Parents are accustomed to hearing what their child isn't doing, so it isn't surprising that they stress the negative too. And this brings us to the assessment process.

The child is screened during this first visit to determine project eligibility. All screening is done in the home, with parental consent and their help by contributing their knowledge of the child. The screening instrument (Alpern and Boll, 1972) which is also used as one of the pre-post measures, is administered as a parental questionnaire together with direct observation of the child's behavior, when possible. In fact, it couldn't be accomplished without them. We have found that the results are likely to be more reliable than if testing were done without the benefit of parent involvement because parents know their children best. Also, since the assessment instruments are administered on the parent's and child's "home ground", results are likely to be more accurate than if the assessment were attempted in a strange environment.

The assessment of the child also becomes the first step in parent training. During this process questions are asked by the home teacher concerning the child's present behavior in five different areas of growth and development. Many parents voice surprise at how much they know about their child in some areas and how little they know about their child in others. Parents make general remarks like: "I must have seen Johnny go up and down steps hundred of times, but I just haven't noticed if he does it with two feet on the same step or if he walks down like I do." If the parent is unsure of the answer to any question, the home teacher tests the child directly.

Many parents verbalize that they don't know if their child can cut with a scissors or ride a trike because they haven't given him the opportunity. Often, just asking the parents the questions gives them the clue to try. One parent called the office two days after initial assessment to report that not only could Suzie now cut paper following a straight line she also took advantage of her new-found skill and gave the family dog a haircut! (Fortunately, the mother was laughing.)

In addition to the Alpern-Boll, the Portage Checklist is also completed (Shearer, Billingsley, Frohman, et al 1972). A complete description of this instrument along with descriptions of other project components can be found elsewhere (Shearer and Shearer, 1972; Frohman and Schortinghuis, in press). This instrument lists a series of behavioral sequences from birth to age five encompassing self-help, motor, language, socialization and cognitive skills. This checklist aids the parent and teacher in breaking developmental tasks into smaller steps and then assessing whether the child exhibits the behavior on entry into the program. What the child can already do determines what he's ready to learn next. The results of the assessment are discussed with the parents. All of the parents' questions regarding the assessment are answered honestly and in understandable language without psycho-educational jargon. When we discuss the assessment with the parent, we emphasize what the child can do. This is because the curriculum the parent will be asked to carry out will be based on what he is ready to learn next. The process itself sometimes makes parents aware of the accomplishments of their children. One father said, "You know, up to this point, all I've really noticed are all the things Ronnie can't do. Guess he's accomplished a few things after all."

After the assessment is completed the home teaching process begins. Based on the information in the assessment, the home teacher often points out three or four behavioral goals that are emerging. The parents are given the choice as to which behavioral goal they would like to target first.

PARENT PARTICIPATION IN THE DELIVERY OF SERVICES—THE HOME VISIT PROCESS

The home teacher writes up an activity chart incorporating the parents' selection of behavioral goals (see figures I and II). The most important point here is for the home teacher to break tasks down and prescribe only those which are most likely to be achieved within one week and can be achieved with high degree of probability. When success on these tasks is achieved the parents are immediately reinforced because what was learned by the child was a direct result of parental teaching. The directions are written in simple, clear language so that the parents can refer to them during the week. The parents are asked to keep simple records on the activity chart. At first recording is uncomplicated and usually involves frequency counts.

First the home teacher introduces the activity to the child and records the frequency of correct responses prior to instruction. This baseline data is recorded on the activity chart. The home teacher begins the teaching process by following the written directions on the activity sheet. The home teacher is thus modeling teaching techniques for the parents—showing them what to do and how to do it. After several trials, the parents model for the home teacher. Extra activity sheets are provided so the parents can practice recording the child's behavior as they work with him while the home teacher is still there. The home teacher then is able to offer sugestions and reinforcement that will maximize the likelihood that

FIGURE 1
ACTIVITY SHEET

PORTAGE PROJECT

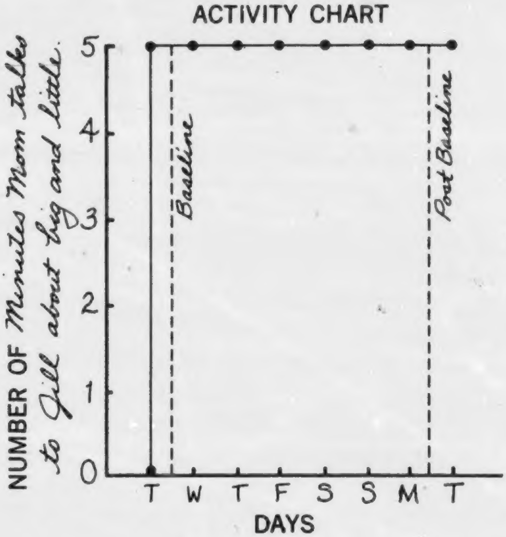
Child's Name Jill

Home Teacher's Name Susan

Week of September 18th

BEHAVIOR:

Mom will tell Jill which of 2 like objects is big and which is little. (5 minutes/day)



DIRECTIONS:

1. Use paired objects or pictures that are the same - except for size.
2. Talk with Jill pointing to and naming the objects that are big and little, and encourage Jill to repeat the size word in imitation of you.
3. Praise her each time she imitates
4. Use as many different examples of like pictures and objects as possible.
5. Record the number of minutes you spend naming big and little each day.

the parents will work effectively with the child during the week and then the child will succeed with the prescribed activity.

Throughout the visit the home teacher stresses the importance of working with the child during the week. The home teacher leaves his or her home and office phone number with the parents and encourages them to call if any question or problem arises during the week. The home teacher returns the following week to collect post-baseline data on the previous week's activities. This helps the teacher validate the accuracy of the parents' recording and provides the teacher with feedback concerning the degree of success achieved by the child and his readiness to proceed to the next sequential step. Based on this data, the home teacher prepares a new activity sheet. On this new sheet the previous prescriptions are altered or new activities are introduced. Baseline data is recorded and so the cycle is repeated. At the completion of each home visit, the parent writes an evaluation of the week's progress, which often serves as an additional source of information for curriculum planning and modification.

Every attempt is made to utilize materials available in the home; however, there are times when materials are brought in and left for the parents to use. This works well because parents take care of materials. During the past five years, only two percent of these materials have been lost or broken.

This is the basic sequence of the home visit process. However in reality, sometimes modifications of the process are necessary. Parents are not the same, thus it is as important to individualize the teaching process for them as it is to do so with their child. The following are examples of how the process has been modified to accommodate individual differences among parents.

Parents Who Cannot Read or Write or Who Are Themselves Handicapped.

One family had eight children, seven of whom were in special education classes. The youngest, a preschooler, was at home and had been referred to the Project by the county nurse. The father kept all intruders away from the house with a shotgun and greeted the home teacher in this manner; however, both parents listened to an explanation of the Project. The conversation took place on the wooden porch which apparently was not able to hold the weight, and it collapsed! The home teacher was asked to come back the next week and, possibly because there was no longer a front porch, she was invited into the house where she met and screened Joey. Based on the assessment it was determined that Joey was functioning at the "trainable" level. After some discussion, the parents agreed to participate in the Project and work with the child.

There were instances when the home teacher had to teach the mother the skill before she could teach it to her son. Sometimes the learning occurred simultaneously. For example, one mother and son learned to name and discriminate between colors together, and both were equally proud of their accomplishments.

Because an activity chart would be of no use to this family, the home teacher relied heavily on demonstrating the teaching process necessary to implement each prescription, and on parent modeling. Recording was done on masking tape that was taped on the kitchen table with one piece of tape representing each day of the week. Hash marks were drawn on the tape which indicated to the mother the number of times the

FIGURE 2
ACTIVITY SHEET

PORTAGE PROJECT

Child's Name Lonnie

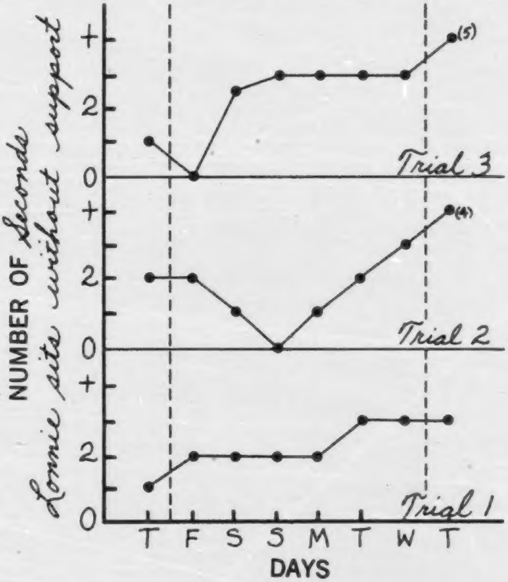
Home Teacher's Name Helen

Week of December 10th

BEHAVIOR:

Lonnie will sit self-supporting without using hands for balance for 3 seconds.

ACTIVITY CHART



DIRECTIONS:

1. Sit on the floor with Lonnie between your legs. Rather then let Lonnie rest against your stomach, place your hand against the small of her back.
2. Give her a special toy like the 'Busy Box' to play with. When she appears to be supporting herself, reduce the pressure on her back.
3. Count the number of seconds she maintains that position without using her hands (putting them on your leg) without back support.
4. Talk to her as she sits.
5. Practise 5 times/day, but just record first 3 trials.

activity was to be practiced. The mother circled a hash mark for each correct response. Two older siblings were interested in the activities so the home teacher involved them in the teaching process too.

After one year in the project, Joey was the first child in this family of eight who was able to enter kindergarten. Testing data indicated he was functioning within the normal range.

Parents Who Do Not Work With Their Child Between Home Visits.

Annie, the target child, was especially low in language skills and so the home teacher wanted to acquaint the mother (this is a single parent home) with the importance of verbalizing to the child. The first prescription was, "Mom will read a story, five minutes in length, to Annie each day." The parent could simply record on the activity chart, "yes" she did read, or "no" she didn't. When the mother still hadn't accomplished the task two weeks later, the home teacher had to think of a system to motivate the mother to read to the child.

The prescription was modified the following week so that the mother would read a short story to the child daily. The home teacher put each story book in an envelope which also contained a small present for the mother, such as a comb or a small vial of perfume. She hoped that the present would motivate the mother to open the envelope, although this was no guarantee she would read to the child.

The home teacher began thinking of another kind of reinforcer for the mother. She knew that the home was lacking in many modern conveniences, like running water. To get water, the mother had to walk one mile every week with a sled or a wagon, depending on the weather, to a nearby tavern which was the closest water supply.

The real payoff was to come at the next home visit. The home teacher had told the mother that if Annie could recall two facts about each of the stories that had been read to her that she, the home teacher, would get the water for the mother that week. The mother worked with the child that week and Annie could recall the facts. The best thing that happened from our point of view was that the mother was so reinforced by her child's success that she no longer needed to be coaxed into working with her child. Three weeks later, the mother said, "It's akay now. You don't have to get my water. I want to work with Annie."

Parents Who Do Not Record

Although all the parents need to do is record the total number of correct responses on the activity chart, there are so many parents that do not record during the first month that a single example would not be instructive. However gadgets like clickers, golf counters, and knitting counters are especially helpful. Even though none of the parents' data is used to add to or modify prescriptions, (baseline and post-baseline data collected by the home teacher determines that) it can serve as a major motivator for the parents because they can see small gains that might otherwise go unnoticed. Extra praise and attention from the home teacher or staying for an extra cup of coffee have been used as a reward for the parent who records. In one case the home teacher had been trying, unsuccessfully, to get the parent to record and the parent had been trying, unsuccessfully, to get the teacher to buy panty hose. They came to a mutual satisfactory trade off—recording data for panty hose.

SOME "HOW TO'S" OF WORKING WITH PARENTS

The Project has learned several important lessons, some of them the hard way, as they relate to working with parents. A few of these suggestions are directly related to working in homes. However, most would be applicable regardless of the instructional setting.

Set Weekly Curriculum Goals

Choosing the goals and writing the prescriptions are the most difficult tasks the teacher faces, and probably the most important. In planning individualized goals for a child and the parents, it is important that the chosen goal be one that can be achieved within one week. There may be times that this goal will not be met; however, it is extremely important that successes occur frequently and quickly, especially in the beginning. When the child succeeds, the parents succeed since they are the ones who are doing the teaching.

At this point the teacher knows from the assessment that the child, among other things, is not toilet trained, doesn't feed himself, has temper tantrums, doesn't imitate sounds, can't sort primary colors and can't hop. Where to begin? Begin where he is—with what he can already do. It really does help to look at the things the child can do, rather than the things he can't. He does stay dry for one and a half hours; he can hold a spoon, dip it and get it to his mouth with help; he does make vowel sounds and some consonant sounds spontaneously; he can sort blue plastic cars from blue plastic spoons; and he does respond to praise and smiles. Now, what could be appropriate beginning objectives that are likely to be achieved within a week? Here are a few possibilities:

- The family members will take Johnny into the bathroom with them and they will model toileting behaviors.
- The mother will place Johnny on the toilet every one and a half hours for no more than five minutes. If Johnny performs appropriately, he will be given praise and a happy face sticker to put on the bathroom door.
- The mother will put Johnny in training pants during the day (not diapers).
- Johnny will sort blue plastic cars and yellow plastic spoons into two groups.
- Johnny will dip his spoon into sticky cereal (oatmeal) without help, will hold spoon without help, and will guide spoon to mouth with minimum aid (slight pressure on his elbow).
- The mother will count the number of tantrums Johnny has each day (baseline information).
- The mother will imitate any sound Johnny makes and she will count the number of times Johnny imitates her.
- Johnny will stand on one foot without support for five seconds.

The choice of activities would depend totally on our mythical Johnny. He determines the curriculum. The choice, in the beginning, should be based as much on the likelihood of success as on the importance of the skill.

Show the Parent What to Do and How to Do It

In teaching any new skill, it is important to model the behavior that is expected. For instance, in teaching a child to sort colors, a teacher wouldn't say, "Okay Johnny, sort colors." The teacher would show him what to do by doing it herself. Adults being taught new skills also learn better when given concrete examples. For instance, a parent is much more likely to deal with tantrums in a certain way if shown how to do it rather than being told how to do it. This means that the teacher may have to instigate a temper tantrum and then show the parents how to handle it. The teacher finds out what typically sets Johnny off and then creates the same situation. If the technique suggested by the home teacher doesn't work, something else is tried until a technique is found that does work. In this way a technique that will work is discovered and the parents are not frustrated by trying something that won't work. Teachers need not be afraid of trying and failing in front of the parents. The teacher is showing the parents that it is alright to make mistakes as long as the prescription is modified to achieve success. The teacher then, is modeling problem-solving behavior for the parents. The moral then is: there is always a solution.

Have the Parents Practice Teaching the Skill

The purpose of the home visit is to instruct the parents to teach the child, and one condition necessary for the parent's learning is the opportunity to practice. After the parents have seen the teacher work with the child and succeed, they need to experience the same success, since there is a major difference in seeing an activity being taught and doing it yourself. Parents need to know they can teach effectively too in the presence of the teacher. Thus, parents will be more likely to carry out the activity when the teacher is not there. Also this provides an opportunity for the home teacher to spot problems quickly. For example, the parent might not let the child know when he is correct, or the parent might be giving too many cues or not enough. If these problems can be corrected before the teacher leaves, then the likelihood that the parents and child will succeed with the activity during the week is greatly increased.

Reinforce the Parents

Another condition necessary to learn new skills is reinforcement. Just as the child is more likely to perform actions that are reinforced, so are the parents. Let them know; tell them when they're doing it right and be patient. It is not reasonable to expect perfection from parents immediately. Sometimes the parent may have to break long-established behavior patterns of his own to be able to apply good techniques in teaching his child. For example, the parent may be used to doing things for the child that he can do for himself, ignoring "good" behaviors and attending to "bad" ones, or not talking to the child because he never responds anyway. It does take time, practice, and reinforcement to change old patterns, and parents should be praised for small improvements. Small improvements lead to big ones!

Individualize for Parents

Some parents have experienced so much failure when trying to work with their child in the past, that they do not want to try again. To change this "I give up" attitude to an "I did it!" attitude may mean that the home teacher must offer parents more tangible encouragements than praise. In one home, for example, the teacher and parent drank a beer together and socialized after the home visit if the child had accomplished the skill. (It was the home teacher's last visit of the day!)

This rather atypical example serves to show that in the beginning, praise alone may not be enough to motivate some parents. However, once parents see that they can succeed and that their child can learn as a result of their teaching, you can substitute praise for more tangible reinforcers. Success is the greatest reinforcer of all, but in some cases extraordinary measures need to be taken just to get the parents involved so they can experience success.

Involve the Parents in Planning

As the parents experience success in teaching their child, the home teacher should reduce her help and involve the parents in planning weekly goals. Thus, the parents do not become dependent on the teacher but become confident and self-reliant in planning the curriculum for their child as well as teaching it. Some parents will reach this stage six months after they begin in the program, and some after six years. The parents should be encouraged to take as much responsibility as they can, but the home teacher should always be ready to give support, reinforcement, help, and encouragement based on the parent's needs.

EVALUATION OF PARENT PARTICIPATION

There are several ways to measure the degree of parent participation. One is to measure the progress of the children. One of the most traditional ways to do this is to compare I.Q. scores. The average I.Q. of the children in the project was seventy-five as determined by standardized intelligence tests. Therefore, it would be expected that on the average, the normal rate of growth would be seventy-five percent of that of the child with normal intelligence. One would expect that the average gain would be about six months in an eight month period of time. However, the average child in the project gained fifteen months in an eight month period. Although the home teachers did help the parents plan the curriculum, these gains in I.Q. could only have been attained through parental teaching.

Another way to evaluate the parents' effectiveness is to test the child after the summer vacation since the program does not operate during the summer months. Children who are too young to go to public school and remain in the project longer than one year are retested in September, and these test results are compared to the scores achieved the previous May. In the past there was no significant difference in the scores although some regression might have been expected. This indicates that the parents continued to work with the child and reinforce him even though the home teacher was no longer making visits.

Ninety children were served by the project last year and the frequency of parental recording over the year's period of time was ninety-two percent. An average of one hundred and twenty-eight prescriptions were written per child over a year's period of time. The children were successful on ninety-one percent of the prescriptions written. This indicates that the parents taught the children during the week, and that, based on post-baseline data taken by the teacher, the children did indeed learn.

The success of this model also can be measured by the ability of parents to plan curriculum without assistance. Approximately sixty percent of the parents have been able to plan curriculum fully and write up activity charts without teacher assistance.

Furthermore, we have found that a significant number of parents are using the teaching techniques learned from the home teacher to change the behavior of other family members, in addition to the targeted child's.

The Project has attempted to conduct surveys about the program after the program year ended to determine if a relationship existed between amount of gains made by the children and the parents' attitudes. However, the parent's comments were so positive that no relationship could be drawn. (Peniston, E., 1972).

We think that one of the most significant informal evaluations of our project was the fact that the parents fought so hard to make sure it was funded. Two years ago (before mandatory legislation was enacted in Wisconsin) federal funds were discontinued for the direct service component of the Project. In order for the program to continue, financial support from local public school districts was necessary. Most school boards were eager for program continuation and contracted with the agency for service. Where there were exceptions, parents organized on their own and went to school board meetings requesting service. They apparently were quite influential since four districts in question did opt to purchase the program. (One father told a school board that if the district didn't buy the Project, he would move his family to a school district that would!)

Final Comments Regarding the Portage Home-Based Program

This model depends upon a structured, concentrated interaction between the home teacher, the parents, and the child. It is important to be task-oriented during the home visit. There is much teaching to do, yet there is usually some time left for having a cup of coffee and socializing. During this time a parent may talk about marital, financial and other personal problems, and the home teacher can, and should, refer the parent to agencies or people who are trained to help. The teacher's expertise is in teaching—not social work, counseling, psychology, or psychiatry—but it is her responsibility to be aware of community resources that can serve these other needs. It then must be the parent's decision to contact or not to contact the suggested sources. The option and decision must be left with the parents.

Each teacher should set up a scheduled day and time for the home visit. If there is a change, parents should be informed. Because a family may have a handicapped child or may be in need of assistance does not mean the family must forfeit their right to privacy.

The teaching staff members may see homes and family life styles very different from their own. Thus, it is vital for the teachers to realize and accept that they are in the homes to aid the parents to learn teaching skills and not to change life styles or value systems. The teacher should remember that he or she is a guest in each home and can only maintain the child-parent-teacher relationship with the parent's assent.

Many educators have, for too long, usurped the parent's role of responsibility in education. This condition may be magnified as more states lower the age for mandatory education for handicapped children by providing early intervention as soon as a problem is identified. Parents of the children being served need guidance and support from teachers but it is equally as important to realize and accept that teachers need parental support and guidance if the children are to achieve, maintain and increase behavioral competence.

The type of program which stimulates direct involvement of parents in teaching their children can provide parents with necessary skills and techniques to become more effective doing what they already do and being what they already are—the single most important individuals in their child's life—his parents and teachers.

The parent-teacher relationship is one built on mutual respect and need for what each can bring to the child. This relationship with the parents and families may well be one of the most satisfying and rewarding that a teacher will ever experience.

ABOUT THE AUTHOR

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Marsha S. Shearer is currently the Training Coordinator for the Portage Project, a home-based project for preschool handicapped children in Portage, Wisconsin.

Her professional interests include providing training and assistance in the areas of parent involvement and precision teaching techniques, and she has done research in developing and refining a curriculum guide for preschool children from birth to five years of age.

She holds degrees from Butler University and the University of Wisconsin and has authored an article in *Exceptional Children* about the Portage Project. She also is a co-author of *Education and Care of Moderately and Severely Retarded Children.*

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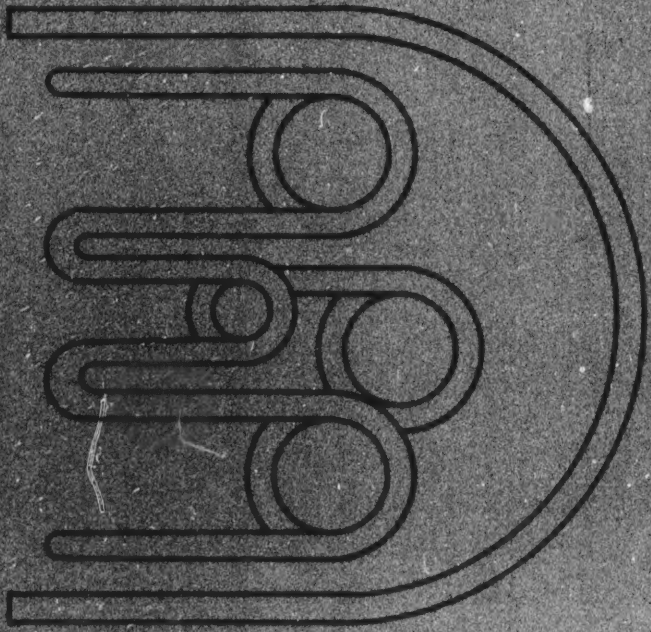
CHAPTER 5



A Parent Implemented Preschool Program

By Ron Wiegerink
Vince Parrish

RATIONALE

There are several substantial reasons for involving consumers, namely parents, in service delivery systems for handicapped children. To identify a few: (1) parents know their own children best and this knowledge can be used to good advantage by others working with the children; (2) often parents spend more time with their children than do others and this time can be used to work with their children in a manner consistent with the center's goals; (3) parents can be of significant help to one another in that they share similar problems and can identify with and support one another; (4) parents can provide the project staff with ongoing evaluative feedback which can assist the program in being accountable and in making programmatic decisions; (5) parents can provide child behavioral data that can be used to monitor intervention effectiveness; (6) parents supply a source of manpower not readily available from other sources because of the lack of finances and training.

Each of these points is worth elaborating upon and most of them have been explored by other authors (Ora & Reisinger, 1971). Clearly, there are not sufficient preschool services for handicapped children. Even though services have increased rapidly since the Handicapped Children's Early Education Assistance Program (HCEEP) came into being, at the rate services are expanding it will be decades before all preschool handicapped children are provided with early assistance and education at the rate services are currently expanding. There are many reasons for this state of affairs: two principal reasons are a lack of financial resources to provide programs for all handicapped children and a lack of trained personnel. To accelerate the provision of services more rapidly, programs are needed which provide quality services for handicapped children at low costs and do not rely completely on professionally trained practitioners for all or even a majority of the intervention services. Currently, programs funded by the HCEEP (Handicapped Children's Early Education Program) are averaging over $3,000 per child served and a ratio of fewer than six children served for the equivalent of each full-time, professionally trained staff member.

While these costs in terms of money and manpower are not too great for a society to spend to assist handicapped children, at present our society is not willing to make these kinds of resources available to serve all handicapped children. Therefore, professionally trained persons who have the responsibility for providing services for all handicapped children must develop and implement service systems which are likely to provide quality services with substantially lower financial and human resources.

Parents are one source of such human resources. They are readily available. They are already engaged in preparing and teaching their children and are eager to learn more effective ways to rear their children and prepare them to live in society.

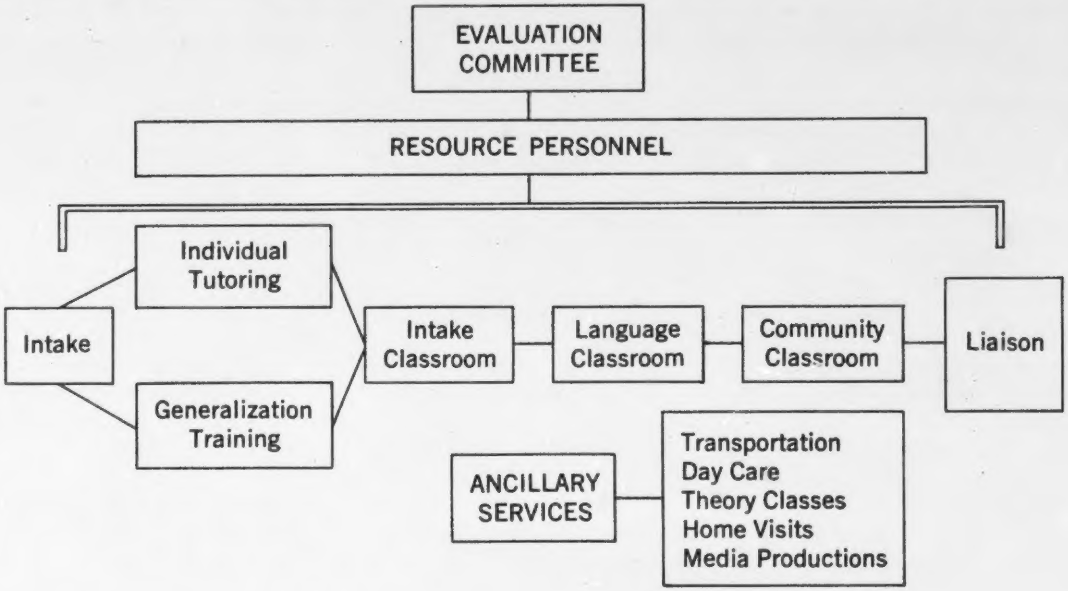
A project that recognized this human resource early in its inception is the Regional Intervention Program of Nashville, Tennessee. This program was one of the first group of projects funded by the Bureau of Education for the Handicapped under the Handicapped Children's Early Education Program in 1969.

The Regional Intervention Program, or RIP as it is called, was described by its first director as "a social experiment in which an agency of people, the Tennessee Department of Mental Health, in cooperation with Peabody College and the Nashville Junior League, provides the citizens of the state with a permanent organizational structure, with support for that structure, and with continuity of information within that structure, but the citizens themselves implement the organization to provide services to their children to their own satisfaction." (Ora, 1972).

The program serves developmentally disabled and behaviorally disordered preschool children from birth to age five from a twenty-six county mental health catchment area. Children and their families are referred to RIP by mental health centers, pediatricians, general practitioners, public health nurses, welfare workers, parents and other agencies when the family is no longer able to cope with the behavior and learning problems of the child. The time between contact with the project and the beginning of service to the family ranges in most cases from twenty minutes to forty-eight hours. Thus, RIP is a flexible service system always ready to admit additional families on a no-reject basis. If the family feels it can profit from the services of the program, it is always admitted.

The decision to become this flexible has meant that RIP had to design a system for delivering services that is capable of readily providing for new families at any time Although originally RIP was designed to provide service through the vehicle of professionals, the utilization of parents in the service soon became a matter of necessity and desirability. A consumer-implemented service system gradually evolved wherein consumers provide all direct service and monitoring of the program, with the support provided by five professionally trained special educators. Designed and implemented as such, it is possible for the project staff (made up of parents and professionals) to provide comprehensive services for approximately fifty additional families during each year of operation. Comprehensive services include transportation, intake, parent training, individual tutoring, preschool classrooms, day care for siblings, medical and behavioral consultation, home visits, liaison with the social service agencies, placement and follow-along. Through these services, RIP's one objective is to pepare the family and the child for the child's maintenance and developmental progress

FIGURE 1
REGIONAL INTERVENTION PROGRAM
STAFF PATTERN


EVALUATION COMMITTEE
RESOURCE PERSONNEL
Individual Tutoring
Intake
Generalization Training
Intake Classroom
Language Classroom
Community Classroom
Liaison
ANCILLARY SERVICES
Transportation
Day Care
Theory Classes
Home Visits
Media Productions

outside of institutional care. This goal is realized if the child continues to make developmental progress after being placed in a regular day care program or public school classroom.

In order to meet this objective and deliver services, RIP is organizationally divided into functional modules which achieve management objectives (Figure I). Each module is supervised by a resource person who has had professional training, but all the services are provided by parents who have been served by RIP. The entire project is monitored and evaluated by an Evaluation Committee consisting of three parents and three consultants who are selected by the parents through procedures established by the committee. This committee meets regularly and has the responsibility for approving and generating project policies and for evaluating ongoing activities. All project personnel meet with the committee at least monthly to report on module activities and individual family progress.

The committee in turn transmits a monthly report, consisting of the minutes of its meeting and its comments on the meeting, to the Coordinator, Preschool Programs Branch, Division of Children and Youth Services, Department of Mental Health. The Coordinator's office has already perceived that such a system permits extremely close and politically astute monitoring with minimum administrative overhead.

The second level of the program is the professional resource staff which provides a middle-management function within the project. Each staff member in this level has specified areas of responsibility which are outlined by management objectives following the format of Reddin's *Effective Management by Objectives* (1971). For example, the principal of RIP is responsible for the overall administrative operations of the program. The professional staff personnel do not provide conventional special education services themselves. They work individually with parents and children only for the purposes of modeling and training, but most direct services are provided by trained parents who these resource personnel continuously consult with, train, monitor, evaluate and direct. Essentially, the professional staff members are consultants to parents responsible for the implementation of the program and providing them with expertise and personal support for planning and teaching.

The third level of the program is delivery of services which is totally parent-implemented. At this level are parents who have received training to work with their own children and have demonstrated particular expertise in at least two domains: technical and interpersonal competence. Their technical competence is, of course, constantly growing and may be in one or more of numerous areas of project services such as intake interviews, child assessment, classroom teaching, individual tutoring, home visits and child management. In every case, however, these consumers have demonstrated that they can operate within a management-by-objectives framework and can reliably utilize the data collection procedures of RIP. For at the center of all RIP services is the importance of objectives and data-based evaluation.

Individual factors such as personality style, interpersonal skills and interests are also considered in determining what responsibilities and functions the parent is to have. These decisions are made by the parents who have provided the new grant with services along with the resource personnel.

Demands for a variety of regional treatment services, constantly shifting referral patterns, and multiple funding sources over the past five years have largely determined the numbers and kinds of clients served by the RIP program. The description of the current program in terms of its clients and referral base which follows will, hopefully, be a useful referent to those interested in the evolution of the Regional Intervention Program.

Between June of 1969 and March 21, 1974, RIP served a total of 254 families. At present, approximately forty families are actively enrolled in the program with an approximate average rate of attendance of 65 percent. Thus, about twenty-six families daily participate in the program. These families have an average of 1.6 preschool children who attend RIP, bringing the program's daily attendance to approximately twenty-six adults and forty children.

The average RIP child is forty-one months old upon referral and generally will remain in the program for 8.1 months.

For the past five years, most of the referrals (76 to 80 percent) were males and approximately one-half of RIP's current referrals could be classified as seriously developmentally delayed; that is, significant delay exists in the language, motoric or cognitive areas. The remainder of the children are non-developmentally delayed, severely behaviorally disordered children who typically have been referred as "brats," oppositional, or hyperactive children.

Currently, 24 percent of RIP's families are black, having been typically referred by local Welfare Department social workers, public health department nurses, child development clinics and, occasionally, a private pediatrician.

In the first two years of operations RIP relied very heavily on local pediatricians from the Metropolitan Nashville area for referrals (in 1970-71, 76 percent of all of RIP's referrals originated from pediatricians). However, over the past three years, the pediatric referral rate has stabilized between 25 percent and 29 percent as more mental health centers, social service organizations and hospital-affiliated diagnostic clinics begin to refer to the program. Thus, the program is now fairly representative of the general population of the middle Tennessee area with 38 percent of its families in an income range below $7,000, 51 percent between $7,000 and $13,000, and 11 percent above $13,000 annual income. Further, as awareness of the program has grown, more families from rural middle Tennessee are daily attending RIP. At present, nearly 25 percent of the program's families travel more than fifty miles per day (round trip) for services and some of these commute over one hundred miles per day.

INTAKE

The purpose of the Intake Module is to familiarize new families with the program, to provide them with support and understanding to determine what are the next steps in providing help for the family, and to invite the parents to join if they wish. The intake process is designed to be as informal, informative, and supportive as possible. Because prescriptive diagnosis and assessment is seen as an ongoing process and an integral part of service itself, there is no need to collect involved diagnostic data. Instead, the parent is asked simply to describe what the child does or does not do that is excessively disturbing. This information is then used to place the family in the correct service module and to identify parents who have had similar problems and can be of help.

Following the intake interview, the parents are shown a slide show describing the program services and are then taken on a tour of the program. It is explained that parents are expected to devote from six to nine hours a week at the program working with their children. However, once a prescriptive program has been designed and implemented for them and their child is making steady progress, they are expected to commit themselves to an additional six months of volunteer work with the project helping others like themselves.

From talking to others who are working, perspective parents, they discover that most parents enjoy working after their child's intensive training needs are met because they perform newly acquired functions that give them a sense of satisfaction and accomplishment. To most parents, the opportunity to acquire talents and abilities they may not even have known they had provides an outlet for self-expression. Also, many of the parents have realized that the program's objectives of helping people to help their children and each other reflect their own values and beliefs. Only after the parents have had a chance to acquire all the information they need does the family make a decision about whether or not to participate in the program. As soon as they join, usually within an hour or so of arriving, case responsibility passes from the Intake Module to a Training Module. The coordinator, who directs the Training Module, immediately assigns other parents who are successfully dealing with similar problems to provide support to the new family until they begin to make friends on their own. A training schedule which usually begins the next day is set up for the child. If the family has other needs, the Training Module coordinator alerts support modules. In consultation with the resource personnel the Intake Coordinator can immediately activate a massive effort from teams of trained workers as well as educational, medical and social services. By the end of the morning, the family has a list showing who to call for what and what to do next. More important, they realize that they are no longer alone. People like themselves whom they can trust are using a carefully designed system to help them.

DIRECT SERVICES

The family and child are then placed in a Service Module, either the Individual Tutoring or Generalization Training Module and a Classroom Module. The first two modules are designed to develop individual programs for the parent and child, and the Classroom Modules provide the child with group learning experiences and his parents with group teaching experiences.

A child unable to communicate appropriately is assigned first to the Individual Tutoring Module. The Individual Tutoring Module's goals are to produce functional speech or other adaptive behavior in the child and to instruct the parents about how to develop these skills in their own child at home. Training begins at the child's present level of development. For instance, it may start with getting him to look at people, to follow instructions, to imitate motions, sounds or words, or to recognize and name things.

In Individual Tutoring rooms the child's mother begins by learning to record which stimuli are presented to the child and how many correct responses he or she makes. Within a few daily sessions the parent becomes the teacher as well as the pupil. The parent presents the training stimuli to the child and reinforces correct responses, teaches the child at home every day and records the child's responses on a data sheet. All program training is designed solely to teach the parents what to do at home. The parent comes in daily to the Individual Tutoring Module to demonstrate progress made in the home program and to confer with the case manager on procedures as determined by the parent's and the child's needs. Individual tutoring experiences such as imitation and speech training are used because they have been repeatedly found to be an effective method of teaching parents. Once skilled in these procedures, most parents can, after a little demonstration, not only teach skills like toileting and dressing, but abide very well by the program's rule for generalization of learning: "Any desirable behavior that the child learns anywhere is thereafter required and reinforced everywhere."

Some families who enter the program do not go into the Individual Tutoring Module because they have other kinds of problems. The Generalization Training Module is designed to take care of these problems. They seek help because their child has brought them near collapse with severe tantrums, constant crying, whining, and general unmanageability. The child may have upset meals, refused to go to bed, abused himself, his parents, his brothers and sisters, and his pets; destroyed things in the home; or defied all attempts by his parents to discipline him.

Assigned to the Generalization Training Module, these families soon learn that the problem does not reside solely in the child. Research has shown that such behavioral disorders in toddlers are acute and interactive and unless help is given at an early age, such children are in for serious problems.

In this module, training for parents and child takes place during a twenty-minute structured play session, which is designed to elicit bad behavior from the child. The parent is instructed to request the child to change toys every two minutes. The parent-child interaction is analyzed by continuous data recording. With the case manager, the parent follows a manual of instructions and videotapes which teach the parents how to assume increasing responsibility for operating the module. As in all the training modules, procedures are primarily designed to teach the parents what to do at home.

In most cases the parent's request for the child to change toys every two minutes results in a considerable amount of oppositional behavior including screaming, throwing objects, sulking, and general unmanageability. Parents often respond to this behavior with almost constant attention as they try to get the child to conform, thus, inadvertently reinforcing the inappropriate behaviors. After baselines on the parent and child behavior are established, parents are taught to ignore inappropriate behaviors and praise and reinforce appropirate behavior. These procedures normally result in significant increase in praise from the parent and sharp decreases in oppositional behavior from the child. Within a three or four week period most parents are taught new and successful child management skills.

While the family is being served in one of these modules they are also assigned to a classroom. Both parent and child begin in the Intake Preschool. In addition, if the family has other preschool children who do not have day care, they are included in the classroom programs.

The Intake Preschool does not have responsibility for the family; responsibility always rests with only one module at a time. Nonetheless, the Intake Preschool is a major training center for both parent and child. Again, a standard training manual is used by the mothers. When the parent has demonstrated that he or she can accurately record a number of dimensions of teacher and child behavior in group situations, the parent and child advance from the Intake Preschool. Continuous data recording shows when the child's behavior is acceptable for one of three other preschools. One preschool is for tiny tots and toddlers who function at the same level. The curriculum is built around developing gross and fine motor skills and saying single words. Another preschool is language-oriented and these children are usually involved in individual tutoring. However, some brothers and sisters or children from the generalization training module are included as language models. The Language Preschool works very closely with the Individual Tutoring Module. Unlike any of the other modules related to group activities, the Language Preschool sometimes assumes responsibility for a family, especi-

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ally when the primary objective is to provide extensive language stimulation so that the child can enter a classroom in the community.

The third preschool is a class designed to be like those the children will encounter in the community. Teacher-pupil ratios are lower here than in other preschools, and social experiences are stressed. As in all the Program's preschools, however, the child is still on an individualized course of instruction; however, he receives less individual attention than in the other preschools. The child's progress is evaluated on a day-to-day basis by recording behavior and comparing it with instructional objectives. The resulting information is monitored by the child's parents, by the teachers and the resource personnel, and by the personnel of the Liaison Module who, at this point, take over responsibility for the family. As the child proves to be ready for return to community schools, the issue of an appropriate match between family and community services arises. The Liaison personnel already have records on the child from the Program's own community preschool, and maintain an empirically evaluated listing of placements appropriate for various children. They investigate possible placements and consult with the parents about the most appropriate placement. When the child moves on to another primary educational system, the Liaison personnel (who are a group of parents that help as they are needed) provide support and consultation to the new teacher. They may actively assist a teacher in programming for a child placed in her class.

Also, should the family encounter further difficulties, the Liaison personnel are the link to the support or intervention systems needed. All the famiiles going back to community services know they can obtain help from the program if they have problems. Conversely, the program does not hesitate to call on its ever-growing network of parents throughout the region for temporary assistance.

PARENT TRAINING

In RIP, parent training and project services are the same; the entire project is designed to help parents help themselves and other parents. Parents are first taught to collect data systematically, using baseline and multiple baseline recording procedures. Data for the purposes of tutoring their child and of evaluating child progress in the preschool classrooms is collected by them. Next, parents are taught the essential skills of behavior modification, reinforcement, timing, shaping, fading, stimulus selection, and programming. As they demonstrate their behavior competencies they begin to receive instruction in the general theories of behaviorism as presented by Skinner (1953) and Bijou & Baer (1961). They then learn more about child development primarily focusing on language development, but also social and motor development.

Once their child is making steady progress and parents have demonstrated competency in some of the basic skills, they begin to offer volunteer services which can be the beginning of a new career for some. If the parents have demonstrated mastery in individual tutoring or generalization training, they can begin as assistants in these modules. If they showed interest in one of the preschool classrooms, they could begin an assistantship there. In some cases, the parents teach others to collect basic behavioral data, but if they show programming and decision-making competencies they can take on more and more responsibilities in one of the service modules.

In most cases parents finish their six months of volunteer service and leave the service-giving aspects of the program but some stay on with the program. In some cases they serve as volunteer assistants but in cases where particular skills and interests are shown, they may become paid employees responsible for a service module such as the Intake Preschool. In some few cases, having demonstrated a good understanding of all functions of RIP, they would take on more responsibilities such as directing the Intake or Liaison Modules or being responsible for parent coordination and assignment. Some of these parents may become members of the Evaluation Committee, or may, with the additional professional training, become full-time resource personnel. Within the program all parents learn important and valuable competencies which they have an opportunity to use continuously in positions of their own choice.

EVALUATION

There are three types of evaluation performed by the RIP staff: individual child progress evaluation, group or module evaluation, and project evaluation. Data are the basis for all decision-making in the program. The success of programmatic intervention is dependent upon valid and reliable data. Therefore, RIP places substantial emphasis on training staff and parents in data-collection procedures that have been designed to measure relevant behavior with reliability.

Individual data are collected in individual tutoring, generalization training, the classrooms, and by the Liaison Module. Using baseline and multiple baseline procedures the staff observes specific behavior in various response classes such as imitations, verbal behavior, motor behavior, cooperativeness, and attending. The data are used to determine the functional effects of the intervention being employed.

Group data are collected primarily by the classroom module. In the Intake Classroom data are collected to determine both individual and group performance on the on-task/off-task dimension. The goal for each child is to be on task 85 percent of the time or more for three consecutive days. During specified times children and tasks are observed by two independent observers. These observers scan the room at specified time intervals and independently record who is on task or off task as well as teacher attention. Percentages of on- and off-task behavior are developed after twenty minutes of classroom observation. These data are used to determine individual child progress as well as group performance as a measure of program effectiveness.

Similar data procedures are used to measure verbal behavior to determine the amount of social play and interaction in the language classroom where the goals are to increase overall expressive behavior and in the community classroom. Here, the objective is for each child to engage in cooperative play behavior at least 40 percent of the time during a free play period. The Liaison Module uses similar procedures to follow-up on children as they are placed in other settings and also to describe and evaluate other preschool programs for the purpose of cataloging potential placement settings for RIP children.

RIP is also constantly in the process of utilizing data to determine overall program effectiveness. The Evaluation Committee regularly evaluates module performance and program effectiveness. In addition, RIP has been the subject of two major evaluations. One was conducted by the research cooperative and funded by the Bureau of Education for the Handicapped. The result of this study was the designation of the Regional Intervention Program as one of twelve exemplary programs for children with behavioral problems in the nation (General Learning Corporation, 1972).

Another study was conducted at the request of RIP staff and on a subcontract basis. The goal of the study was to determine RIP's cost effectiveness as a service program. The results of this detailed cost analysis study are published by the General Learning Corporation (Final Report, 1972).

These figures, however, do not reflect some of the program's non-monetary benefits:

1. probable prevention of behavior problems in children born to mothers subsequent to the mothers' training at RIP,
2. development of trained volunteers who could prove useful to other community action programs,
3. improved manageability of children in public schools,
4. provision of a laboratory for testing novel approaches to keeping family life intact
5. possible reduction in juvenile delinquency for children treated in RIP,
6. training in marketable skills for parents, and
7. possible additional tax revenues resulting from gainful employment of parents who may have been unable to work without RIP involvement.

In summary, the Regional Intervention Program is a service delivery system carefully designed to provide for, and implemented by, parents of developmentally disabled and behaviorally disordered children. It is a system which is managed by stated objectives and evaluated by data to serve the best interest of the children and parents. It is a service through which parents learn to help themselves and others like them at costs which are lower than custodial and institutional care.

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Vince Parrish is the principal of the Regional Intervention Program in Nashville, Tennessee and his professional interests include consumer implementation and evaluation of human service programs and parent training.

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The authors state the case for research based on naturalistic observations and report on their studies of a large sample of mother-child pairs interacting in a "free play" setting. Their "most striking" finding is that, among the "normal" pairs that have been studied, ". . . free-play interaction shows many similarities across families. There are ethnic, social-class, and age differences, but they are relatively small variations on a very consistent theme. . . ."

These findings do not hold, however, in their preliminary data analysis of mother-child pairs in which there is "real [psychological] disturbance."

The authors provide a valuable discussion of some of the methodological and ethical barriers to smooth sailing in this kind of research, matters of obvious concern to professionals who work with young children and their families.

Baldwin, V., Fredericks, H. D., and Brodsky, G. Isn't it time he outgrew this? or A training program for parents of retarded children. Springfield, Illinois: Charles C. Thomas, Publisher, 1973.

This manual contains specific programs by which parents can develop the types of desired behaviors they wish to see in their retarded child. The parent, without prior training or consultation from professionals, should be able to implement his own specific programs and measure the progress of his child by utilizing the behavior modification techniques and basic learning principles described in this book.

In non-technical language the book presents detailed explanations of learning principles involved in self-help skills, language development, motor development, academic skills, and behavior problems.

Included is just enough theory to justify the time invested by the parents who will implement these strategies and programs.

The manual is useful primarily to parents, whether in a group or as individuals; however, the book addresses itself also to the professional involved in parent training. The goal is to involve the parents as the principle teacher of their retarded child.

The Exceptional Parent. Boston, Massachusetts: Psy-Ed Corporation.

This periodical offers practical information for parents of children with all kinds of handicaps. Day-to-day care and long range planning are issues covered by professionals.

A few of the topics covered are professional information, without professional jargon, on key issues such as psychological testing, visits to the dentist, "fun stuff" to make for parents and kids, general discussions of disabilities, and a parent forum with questions and answers from parents.

This magazine is a forum for the mutual sharing of information by parents and professionals concerned with handicapped children.

Jelinek, J. A., and Kasper, A. G. The University of Wyoming communicative disorders and parent training program: Program procedures and activities handbook. Grant Project No. OEG-0-70-4696 (616), Office of Education, U.S. Department of Health, Education, and Welfare.

The Parent Training chapter of this volume is a clear and comprehensive statement of parent training objectives for the program, and includes many of the materials used for training parents.

Johnson, C. A., and Katz, R. C. Using parents as change agents for their children: A review. Journal of Child Psychology and Psychiatry, 1973, 14, 181-200.

A comprehensive review of studies in which parents were used as agents for changing their children's behavior, the paper covers not only the varieties of behavior to be changed, but the various methods used for training parents to effect change. For instance, the authors criticaly review instructions to parents for their clarity or vagueness; one contribution that will be appreciated by professionals in the field is an estimate of therapist's time invested in all the studies reviewed. As the authors note, "some critical methodological issues—data collection, reliability of measurement, demonstrations of behavioral control, follow-up, and cost-effectiveness factors . . . require routine and more careful consideration before the efficacy of parent therapists can be adequately assessed."

LaCrosse, E. L. Planning for the needs of multihandicapped children and their families. Regional Conference for Parents of Deaf-Blind Children, 1973.

While this paper will be of interest to all who are concerned with handicapped children, the first half of the paper should be required reading for any professional who works with the children's parents and famiiles. LaCrosse offers a telling critique of the attitudes of professionals who work with parents, and of the research that has been done on parental attitudes. From there on, he presents a cogent and comprehensive plan for meeting the needs of handicapped children and their families that starts with birth and follows the children into adulthood. For instance: "Along with all of this is a built-in counseling service that is always there to assist the parents in the decisions that have to be made as the youngster grows—not the decisions, but the assistance with the making of decisions, someone to whom you can go and think out loud and receive guidance as to what is available, what is going on, and what it all means."

Marshall-Poweshiek Joint County Department of Special Education. Home stimulation of handicapped children. Marshalltown, Iowa.

This is a very complete guide for parents to use at home with their children. It is a "how-to" manual that contains many excellent concrete suggestions for ways to stimulate a preschool child at home.

Many areas are covered including: behavior modification, how parents can enhance creativity, discipline, toys vs. learning tools. Each chapter has a learning episode evaluation for parents to complete.

It is written in such a way that it can be utilized by all types of parents either in groups or individually. There is an accompanying guide for use by professionals as they work with parents in groups. It shouldn't be limited to parents of handicapped children.

Marx, O. H. Physical activities for handicapped children in the home. Iowa City: The University of Iowa, 1972.

This manual was developed for use by parents of physically handicapped children attending the Children's Rehabilitation Section at the University Hospital School, The University of Iowa. Activity descriptions and construction information on equipment may be utilized by other personnel such as physical education teachers or special education teachers. Guidelines are given for planning the home program in addition to a major section on suggestions for teaching physical skills: Part I discusses basic developmental activities which progress from head lift to walking skills. Part II describes elementary skills such as catching and self testing, equipment, starting position, and skill analyses. In the subsequent section on braces, information is given on application, removal, and maintenance of braces. Photographic illustrations of orthopedic apparatus and physical education equipment is shown in addition to line drawings for the construction of homemade apparatus. A glossary of terms is included.

A mediated training program for parents of preschool mentally retarded children. Instructional Technology Project, Logan, Utah: Utah State University Special Education.

This mediated training package is designed to equip parents of preschool mentally retarded children with the techniques necessary to train their children in self-help skills.

The package contains four units; each unit has a participant's workbook and slide tape program. The units are: behavior (analysis of complex behaviors and the synthesis of simple behaviors into an instructional sequence), cues, reinforcement, programming and record keeping. A monitor's manual and script book are also included.

This package could be very useful in teaching parents how to teach their children. It would require a skilled monitor and dedicated parents.

Ora, J. P. "Parents and Citizen Workers," Invisible College Conference on Early Childhood Education and the Exceptional Child. Reston, Va.: Council for Exceptional Children.

This 20 minute tape discusses citizen workers as early educators of the handicapped.

Ora discusses citizen involvement in terms of: examples of programs utilizing parents; why parent implemented systems are important; citizen workers as a solution to the manpower crisis; and, the role of the professional as developers of automated instructional systems.

This tape presents provocative ideas to stimulate thinking about citizen involvement. The concepts and language are sophisticated but the ideas are excellent and worth listening to.

$75.00 for complete set of five sixty-minute cassette tapes, made by 13 professionals.

Stedman, D. J., Anastasiow, N. J., Dokecki, P. R., Gordon, I. J., and Parker, R. K. How can effective early intervention programs be delivered to potentially retarded children? A condensation of a Report for the Office of the Secretary of the Department of Health, Education, and Welfare. (Contract HEW-OS-72-205) Washington, D.C., DHEW, December, 1972.

In their summary of this project review, the authors state that "In general, intervention research appears to be a fruitful endeavor but in need of considerable refinement prior to massive dissemination of children's services." The critical words are **considerable refinement,** suggestions for which pack this condensed report. Of particular interest is a theme that recurs throughout the report: the role of the parents and families of target children. "Early family involvement . . . [has] a significant impact on a child's development before he reaches his second birthday . . ." is a major finding of intervention research, say the authors. Yet in programs reviewed, "the factor of varying parental support has been largely ignored." A panel of early childhood experts consulted by the authors cites the varied roles parents play in their children's programs, and they recognize parent involvement as a major criterion for program success. Yet they, too, mention, among other criticisms, the failure of programs to research thoroughly the relationship between parent and child behavior and to develop materials for parents to use in their homes.

Perske, R. New directions for parents of persons who are retarded. Nashville, Tennessee: Abingdon Press, 1973.

[Annotation by PCMR **Message**, January, 1974] Written especially for parents who elect to keep the retarded family member in their own home or a nearby residential facility. Four sections focus on "yourself, your child, the family, and society." Delightfully illustrated by Martha Perske.

Partners in language—A guide for parents; Companeros en el idioma—gura para los padres. Washington, D.C.: American Speech and Hearing Association, 1973.

This book is concerned mainly with the normal language development of the young child, from birth to approximately three and one-half years of age. It was developed to increase parents' understanding and knowledge of early childhood language acquisition; and to provide useful suggestions to parents for developing communicative competence in young children by utilizing normal, daily activities as language learning experiences. Through the booklet, parents are encouraged to remember that every child is a unique individual whose rate of development in all areas is also unique.

Simplified developmental charts are included so that parents will be aware of some broad expectations in children's development.

This booklet has beautiful illustrations that reflect different ethnic groups. All materials is written in both Spanish and English in easy to read format.

Preschool learning activities for the visually impaired child: A guide for parents. Springfield, Illinois: Instructional Materials Center.

This manual is for parents of blind children to suggest activities and games that will help develop their child's skills and abilities at home. It also gives parents concrete suggestions for daily interaction with their child such as, "always place the child's tablewear in the same position."

Games and activities are listed according to the types of skills they develop and include: what do I touch, what do I hear, I use my body, the child looks at himself.

Each section is divided into activities for three-, four-, and five-year olds that have normal development with the exception of visual impairment. At the end of each section is a list of suggested materials and where they can be obtained. Most of the items listed are expensive, but moderately priced substitutions could be easily made. Directions and words for songs and games are also included.

This manual has excellent pictures, and the format is easy to follow. It would be a very valuable resource to both parents and teachers.

The Portage guide to early education. Portage, Wisconsin: Cooperative Educational Service, 1973.

The Portage Guide to Early Education is a developmentally formulated curriculum to be used with children, either handicapped or normal, between the mental ages of birth to five years. These materials can be used regardless of the specific handicapping condition(s), of the instructional delivery system (home, classroom, institution), of the teacher/child ratio, or of the professional status of the instructor.

The Guide comes in two parts: a Checklist of Behaviors and a Card File containing curriculum ideas. These materials were developed and utilized by the Portage Project staff over a period of four years. Professional educators, paraprofessionals and parents have used these materials as a major source of behavioral evaluation and assessment and as a curriculum guide.

The Checklist and Card File are color coded and divided into five developmental areas: cognitive, self-help, motor, language, and socialization.

Pushaw, D., Collins, N., Czuchna, G., Gill, G., O'Betts, G., and Stahl, M. Teach your child to talk. Cincinnati: CEBCO Standard Publishing Co., 1969.

This training package is designed to provide parents of preschool children with a better understanding of how they can help children learn to talk.

The complete workshop kit contains:

(1) Workshop manual—(152 pages) complete lesson plans for 3 workshops
(2) 200 35 mm color slides—augment the workshops
(3) 19 minute cassette tape recording—examples of child's speech
(4) 16 mm color movie—summarizes the major points made in the workshop
(5) parent handbook—gives normal speech guidelines at appropriate age levels. Also included are suggested activities that parents can share with children and a suggested book list.
(6) "Teach Me to Talk" booklet—cartoon booklet designed for parents of newborn children.

These materials would be useful with any group of parents that are interested in language development. The workshop is designed in such a way that it could be presented by most persons. The Parent Handbook is a useful resource and could be used separately.

Report of First National Home Start Conference, St. Louis, Missouri, April 3-7, 1972. Washington, D.C.: Home Start.

This report describes the Home Start conferences in narrative form. The focus of the Home Start effort is home-based programs for preschool children; this report contains excerpts from speeches given at the conferences, listings of films used, and descriptions of home-based programs that were presented. It is an excellent resource for information about home-based programs since most of the major home-based programs are represented in this booklet.

Williams, D. and Jaffa, E. Ice cream, poker chips, and very goods: A behavior modification manual for parents. College Park Maryland: The Maryland Book Exchange, 1971.

The purpose of this manual is to teach parents the basic concepts and language of behavior modification; to train parents in the practical application of these techniques with their own children; and to increase the frequency of the parents' use of these techniques within the home.

The basic content of the manual is directly derived from the research literature related to the functional analysis of behavior. It covers reinforcers, changing behavior, and maintaining changes.

It is organized a great deal like a textbook; therefore, it would not be appropriate for all levels of parents. However, it is useful with more sophisticated parents and could be used in groups or individually.